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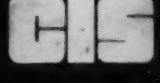

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FAMILY PLANNING AMENDMENTS OF 1989

HEARING

BEFORE THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

S. 110

TO REVISE AND EXTEND THE PROGRAMS OF ASSISTANCE UNDER TITLE X OF THE PUBLIC HEALTH SERVICE ACT

MAY 9, 1989

Printed for the use of the Committee on Labor and Human Resources

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FAMILY PLANNING AMENDMENTS OF 1989

TUESDAY, MAY 9, 1989

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 2:35 p.m., in room SD-430, Dirksen Senate Office Building, Senator Edward M. Kennedy (chairman of the committee), presiding.

Present: Senators Kennedy, Adams, Hatch, Kassebaum, Mikulski, and Coats.

OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. The committee will come to order.

We have had a very long day in this hearing room. Only a few minutes ago Senator Harkin recessed the full committee that had its first extensive hearings on the Americans With Disabilities Act. And we had a press conference prior to that, with strong bipartisan support, from all of the members of this committee. We are very hopeful of being able to have the Administration support the bill and mark it up in June.

The hearing included very moving presentations from a series of different individuals, which certainly made the compelling case for eliminating the existing barriers which leave so many of our fellow citizens out and deny them essential rights which all of us assume this Nation is committed to, but too frequently we forget.

So, we come to order this afternoon on matters of priority for the Labor and Human Resources Committee, the reauthorizations of Title X and Title XX of the Public Health Service Act. Friday is the time we have set for marking up of the two bills we are considering today.

It seems to me that our committee has good awareness and understanding of these issues and certainly the importance of them. I share the frustrations which many will speak of that we have not been able to have these authorizations considered in the Senate. But we are going to make every effort not only report these titles expeditiously, but then to move toward action on the Senate floor. That is certainly my strong commitment, and we will take it there.

Today's hearing concerns two important items of unfinished business from the last Congress—the reauthorizations of Titles X and XX of the Public Health Service Act.

The primary purpose of Title X is to provide services and information to reduce the incidence of unintended pregnancy, to improve maternal health and reduce the need for abortion.

Title XX awards grants to organizations which undertake prevention programs designed to lower the incidence of adolescent pregnancy or to provide health care and social services to pregnant and parenting teenager who might otherwise have negative pregnancy outcomes, drop out of school and remain financially dependent or become pregnant again too soon.

We intend to report these reauthorizations to the Senate as quickly as possible.

Restoration of Title X services to the 1980 level in real dollars is a matter of major public health concern. In addition to the main purpose of Title X services, several other specific goals are addressed. This program helps stem the spread of the deadly AIDS virus to newborn infants. It is also an essential component of overall strategies to reduce the incidence of low birth weight, the strong predictor of infant mortality.

A nationwide system of over 4,500 local clinics, funded in part by Title X, provides 5 million women annually with access to family planning primary care services. These health centers are often the first place that low-income women receive medical care, but less than one-half of those eligible for the program are currently being served.

Since its enactment in 1970, Title X has specifically prohibited the use of its funds for abortion. Despite this prohibition, the program has been unfairly attack by organizations which oppose family planning. But destroying Title X would inevitably lead to more unintended pregnancies and more abortions.

S. 110 provides a 3-year reauthorization of Title X, with a small increase in funding to meet the needs for basic services. Two new initiatives provide funds for applied research on new contraceptive methods, for the National Institute for Child Health and Human Development, for grants to public and private nonprofit organizations for a community-based information and education program.

Roughly one-third of the Title X service recipients are adolescents. Contraceptive services are necessary in the effort to prevent adolescent pregnancy. They are not, however, a sufficient Federal response to this serious social problem. Therefore, we introduced S. 120 as a renewed commitment by Congress to address the problem more fully.

More than 1 million adolescents become pregnant every year. More than 400,000 have abortions; almost 470,000 give birth. There are significantly increased health and financial risks for teenage mothers and the children. The 1987 report by the National Academy of Sciences, "Risking the Future," details the devastating impact of teenage pregnancy and calls for a strategy with multiple approaches. Since 1981, Title XX demonstration projects have been the only Federal program exclusively designed to deal with these issues.

With a relatively small authorization of $10 million annually, Title XX, the Adolescent Family Life Act, has helped support educational services for non pregnant teens and their parents as well as services for teen parents, including prenatal and post natal care and referral for employment, educational, vocational, and adoption counseling services.

Several of these demonstration projects have shown promise in dealing with adolescent pregnancy and its consequences. The need for a more substantial program is obvious. After eight years of experience, it is time to transform Title XX into an ongoing service program that rewards effectiveness with enduring fiscal support.

S. 120 includes a renewed emphasis on high-quality program evaluation. The Federal Government should not support programs that have failed to demonstrate effectiveness in reducing the incidence of adolescent pregnancy or improvements in the outcomes of adolescent pregnancy.

In this time of fiscal constraints on the Federal budget, it is especially important that Congress support cost-effective, preventive health programs.

Taxpayers spend about $19 billion a year to support teenagers and their children. This figure does not include the costs of neonatal intensive care and other medical bills that result from low birth weight and high-risk births to teenage mothers. We must do a better job of preventing teenage pregnancy. When teens do become pregnant, we must provide high-quality, compassionate medical care and facilitate the completion of their education and attainment of productive employment.

I look forward to enactment of these two important bills.

[The prepared statement of Senator Kennedy follows:]

PREPARED OPENING STATEMENT OF SENATOR KENNEDY

The CHAIRMAN. Today's hearing concerns two important items of unfinished business from the last Congress—reauthorization of Titles X and XX of the Public Health Service Act. The primary purpose of Title X is to provide services and information to reduce the incidence of unintended pregnancy, to improve maternal health and to reduce the need for abortion. Title XX awards grants to organizations who undertake prevention programs designed to lower the incidence of adolescent pregnancy, or to provide health care and social services to pregnant and parenting teenagers who might otherwise have negative pregnancy outcomes, drop out of school and remain financially dependent, or become pregnant again too soon. We intend to report these reauthorizations to the Senate as quickly as possible.

Restoration of Title X services to their 1980 level in real dollars is a matter of major public health concern. In addition to the main purpose of Title X services, several other specific goals are addressed. This program helps stem the spread of the deadly AIDS virus to newborn infants. it is also an essential component of overall strategies to reduce the incidence of low birth weight, the strongest predictor of infant mortality.

A nationwide system of over 4,500 local clinics, funded in part by Title X, provides 5 million women annually with access to family planning primary care services. These health centers are often the first place that low-income women receive medical care, but less than one half of those eligible for the program are currently being served.

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gram has been under unfair attack by organizations which oppose family planning. but destroying Title X would inevitably lead to more unintended pregnancies and more abortions.

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After 8 years of experience, it is time to transform Title XX into an ongoing service program that rewards effectiveness with enduring fiscal support. S. 120 includes a renewed emphasis on high quality program evaluation. The Federal Government should not support programs that have failed to demonstrate effectiveness in reducing the incidence of adolescent pregnancy or improvements in the outcomes of adolescent pregnancy.

In this time of fiscal constraints on the Federal budget, it is especially important that Congress support preventive, cost-effective health programs. Taxpayers spend about $19 billion dollars a year to support teenagers and their children, and this figure does not include the costs of neonatal intensive care and other medical bills that result from low-birth weight and high-risk births to teenage mothers.

We must do a better job of preventing teenage pregnancy. When teens do become pregnant, we mut provide high quality, compassionate medical care and facilitate the completion of their education and attainment of productive employment.

I look forward to early enactment of these two important bills. My colleague Brock Adams will chair the remainder of this hear-

ing, but I want to take the opportunity to commend the witnesses for their contributions to these two important measures.

I might just say, finally, that we had an important ruling by the circuit court up in my part of the country in the last couple of days sustaining the lower court in terms of moratorium on the previous recommend regulations which would have, I believe, gone into effect and misrepresented both the legislative history and those who have been the prime architects of this legislation over a considerable period of time. I will include that as part of the record.

[The circuit court ruling follows:]

[FROM THE WASHINGTON POST, TUESDAY, May 9, 1989]

APPEALS COURT NULLIFIES U.S. RULES ON ABORTION COUNSELING

Boston, May 8—A Federal Appeals Court today threw out pending Government rules that would ban abortion counseling by family planning clinics, ruling them unconstitutional.

The ruling by the 1st U.S. Circuit Court of Appeals, upholding a permanent injunction against the rules, was the first on an appellate level among challenges brought separately in Massachusetts, Colorado, and New York to regulations that had been slated to take effect last year.

"This is a resounding victory for a woman's right to make a most personal decision without Government interference," said Massachusetts Attorney General James Shannon, who sought the injunction along with 14 national family planning associations.

Nabers Cabaniss of the U.S. Department of Health and Human Services said the Department would have no comment until it had studied the ruling.

Doug Johnson, legislative director of National Right to Life, said he was surprised the appeals court acted before the Supreme Court could rule on a recent Missouri challenge to the 1973 *Roe* v. *Wade* decision decriminalizing abortion.

Scott Swirling, executive director for the Washington-based National Family Planning and Reproductive Health Association, called the appeals court's decision "a major victory for patients and health professionals and family planning clinics."

A U.S. District Court in Colorado also has found the regulations unconstitutional, and a circuit court hears that case Thursday. A District Court in New York has ruled the regulations, legal; a circuit court ruling is pending.

Swirling and Shannon said the Boston court's decision will have a more sweeping impact than the others because Swirling's group represents more than 85 percent of the federally funded family planning clinics in the country and was a party to the Massachusetts appeal.

The regulations, passed under the Reagan administration, sought to eliminate Federal funding to family planning groups that counseled pregnant women about abortions. The rules would force these groups close or relocate if they shared space with anyone offering pregnancy or abortion counseling or referrals.

In affirming the March 1988 injunction by U.S. District Court Judge Walter Skinner, the appellate court said a prohibition on abortion counseling or referral "imposes constraints upon a women's freedom to make reproductive decisions."

Relying on *Roe* v. *Wade*, the appeals court said that by imposing the regulations, Health and human Services then-Secretary Otis R. Bowmen "has gone beyond a mere refusal to fund and has interfered with the decisional process by dictating what information a woman may receive and by intruding into her relationship with her physician. This he may not do."

The CHAIRMAN. I am pleased to hand the gavel to Senator Adams, who has taken a great interest in these issues and has been very supportive of these measures both here in the Senate as well as in the House. I am very grateful to him for that.

Senator ADAMS [presiding]. Thank you, Mr. Chairman.

It is a great pleasure to be able to chair the hearings today for Senator Kennedy, and I am particularly pleased that we have an opportunity at this time to right a great wrong in American socie-

ty. We too often discuss the highly volatile issues of what to do with our children, how our children will be raised, and whether or not women will have children. These two programs we will discuss today are certainly complementary portions to that discussion of what is necessary to make us a better society in that regard.

I am pleased to be here today to chair this hearing because it is of critical importance. I welcome Senator Kassebaum and Senator Mikulski.

The reauthorization of Title X and Title XX of the Public Health Service Act is necessary to assure that there is support available for family planning and for activities to address the growing problem of adolescent pregnancy in our Nation.

It is not just enough to simply help people to say no. An examination of the facts makes a compelling case for this legislation. More than 1 million teenage girls in the United States became pregnant last year. Nearly 65 percent of those who became mothers were under 14—under 14. And 50 percent of those 15 to 19 do not complete high school. Without education or skills to sustain employment, these young mothers and children increase welfare and social costs as well as threaten our Nation's ability to improve productive performance and prosper economically in the future.

We talk a great deal about competitiveness, the economic future and where this Nation should be going. But the sole base on which all of this rests is our children. And this, as we will hear today from our witnesses, is a wasting resource unless we adopt programs such as are being debated and discussed today.

Studies have shown that teenage mothers who are captive to a cycle of poverty are generally more likely to have children that become unwanted, have more congenital defects and more acute illness. These children will have earlier onsets of sexual activity and have more episodes of delinquency than do those children who are not from this reproductive and socioeconomic environment.

In other words, wanted children are children who are cared for and who care more and understand their society better.

Five million American women each year depend on Title X as their only source of family planning, and for their basic health screening, their referral information, and other aspects concerning their reproductive health.

Continuing support for Title XX activities must be available to address adolescent sexuality and pregnancy, the problem of low birth weight, and the growing AIDS epidemic which is affecting babies, as we all know.

Both S. 110 and S. 120 were reported favorably by this committee during the last Congress. But no further action was taken on either piece of legislation. Rather, absent this reauthorization legislation, these programs have been funded through continued annual appropriation bills.

The witnesses we have today will help us ensure that we move forward to put in place an authorization on this important priority without further delay.

We have a distinguished and comprehensive panel of witnesses today. We will hear the views of the Administration; Dr. Daniel Federman of the Harvard Medical School, who will summarize the research on the medical and social causes and results of adolescent

pregnancy; Faye Wattleton, president of Planned Parenthood Federation of America, an organization whose local affiliates provide 27 percent of the Title X services each year; Thomas Ring, president of the National Family Planning and Reproductive Health Association; Caroline Gaston, National Organization of Adolescent Pregnancy and Parenting; Dick Glasow, National Right to Life Committee; and two recipients of services under these programs.

We are glad you could all join us today. We will begin by hearing from Nabers Cabaniss, Deputy Assistant Secretary for Population Affairs, the Department of Health and Human Services.

So, at this point I would now turn to my colleagues and ask if any of them have opening statements.

Senator Hatch?

Opening Statement of Senator Hatch

Senator Hatch. Well, if I could make an opening statement, I would appreciate it.

Today we begin the debate and the discussion of the reauthorization of two Public Health Service programs: Title X, the Family Planning Act; and Title XX, the Adolescent Family Life Act.

The family planning programs of Title X have provided many women with access to family planning services. At the same time, the Adolescent Family Life Act has provided teenagers with important options by encouraging teens to delay the onset of sexual activity.

Our society is currently confronted by a number of serious social issues. It is important that we frankly and fully consider these sensitive issues and their effects on the delivery of family planning services. We are confronted with conflict surrounding the separation of abortion services from family planning services, the role of the parent in providing family planning services to teenagers, the ability of teenagers to make intelligent decisions about risks and benefits of contraceptive alternatives, and the increased incidence of sexually transmitted disease in our society, especially AIDS.

It seems to me that there are no easy answers and no single solution to address all of the differing needs confronting this program. It remains apparent that individual citizens, acting through their States, must have the right to provide family planning services in the way that they feel is best.

I support the provision of family planning services to low-income women. I do not support abortion services, and I do not support the Government policies that drive wedges between children and their parents.

I also supported the search for new ways of reducing the spread of venereal diseases, teenage pregnancy and, of course, infant mortality.

Unfortunately, too many women today must accept a new form of contraceptive, a contraceptive which has not been approved by the Food and Drug Administration and a contraceptive that they did not choose. It is devastatingly effective in preventing conception. The contraceptive is PHD, or pelvic inflammatory disease. Women are becoming infected with sexually transmitted disease such as gonorrhea, syphilis, chlamydia, and herpes. These diseases

cause inflammation of their fallopian tubes and, unfortunately, can lead to infertility. We are seeing increasing numbers of women who cannot become pregnant because their fallopian tubes are permanently scarred from past sexually transmitted disease infections.

We are also confronted with a new problem, a problem which we did not foresee even a decade ago, and that is acquired immune deficiency syndrome.

If the estimates from the Centers for Disease Control are accurate, more than one out of every 250 Americans is already infected with the AIDS virus. I think it is obvious to everyone that family planning clinics have a duty to change the type of counseling provided in response to this crisis.

Title X clinics now more than ever have a duty to encourage teenagers to abstain from sexual activity. Title X clinics now have a duty to recommend barrier contraceptives as the first choice to individuals with multiple sexual partners. And Title X clinics now have a duty to see that individuals who are concerned that they have AIDS have ready access to testing.

We all know that it is only a matter of time until a witness comes before us who went to a family planning clinic as a teenagers and received her birth control pills. She faithfully took them and did not become pregnant, only to find that she is dying from AIDS. This committee has an ethical and moral obligation to take every step possible to prevent this story from having to be told.

Today, we will hear two stories about how our existing system helped one women but failed another. These stories come from two women who as teenagers were trying to deal with the possibility of pregnancy. One of them went to a family planning clinic, yet still ended up becoming pregnant, a pregnancy which ended in an abortion. The other one became pregnant and, since having the child, has actively used Title X services to help her continue her education.

I think the contrast that is drawn by these two stories shows that Federal programs should not target a single solution to address the needs of women and teenagers in our society.

The State of Utah has taken some bold action to reduce teenage pregnancy. They have passed laws which have been barred from implementation because Federal courts have held them to be contrary to congressional intent. I will again ask the members of this committee to support a waiver authority to test the effectiveness of the Utah law which requires parental consent prior to the dispensing of contraceptives to unemancipated minors.

I for one believe that we should consider and test all possible ways to reduce the number of teenage pregnancies. If the Utah State legislature is right, we should not prevent the success of their program. No one person or organization, and certainly not the Federal Government, has a lock on the answer to reducing teenage pregnancy.

We must also measure the effectiveness of the existing Federal programs for family planning. For example, what is the role of the family planning program in reducing infant mortality in America? Should we be consolidating services to low-income women so they have access to a wide range of health care, including prenatal care services? And finally, shouldn't family planning programs warn

participants of the risks they face in contracting AIDS or other sexually transmittable diseases?

I have seen little evidence that they are doing so in an effective manner. If our family planning clinics are not performing effective counseling, they are doing a major, indeed a tragic, disservice to their program participants.

Now, these are very sensitive and delicate issues that we have to deal with as we begin our deliberations on this legislation. I hope we can consider these issues rationally and responsibly in the spirit of what is best for the American public.

I want personally to welcome all the witnesses before us today and look forward to hearing the testimony of each and every one of you, and I hope that we can come to solutions to some of these very, serious problems that face families and people throughout our country today.

Thank you, Mr. Chairman, for allowing me this time.

Senator ADAMS. Thank you, Senator Hatch, for an excellent statement. We look forward to your help and support in this matter.

Senator Mikulski, do you have an opening statement?

OPENING STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Just very briefly, Mr. Chairman.

First, I would like to welcome all the witnesses who will be testifying today from the Administration and my own constituent from Maryland, Stephanie Jones, who is at the Laurence Paquin School, a school that has had a distinguished history for more than almost two decades of dealing with young women who become pregnant while they are of high school age, a spectacular program that not only keeps the girls in school and ensures their education but essentially gives them the kind of background they need to be a mother and then to move onto the mainstream of life. I know that she is accompanied by our principal, Rosetta Stitch, who also has done an outstanding job. So, we welcome them.

Mr. Chairman, just very quickly, I know we are going to pay a lot of attention, hopefully, to the Title X reauthorization, something that we advocated last year and could not get passed in the Congress. I feel that Title X is one of the most important self-help tools that the Federal Government can provide to women. It is access to information, an access of information that enables them to control not only their own bodies but their own destinies.

If you talk to social workers the way I do, they will tell you very often for women on welfare one of the first steps to getting people into the training programs is to help them to get family planning so that they can get control over their lives.

Last, but not at all least, is we deal with the adolescent pregnancy prevention issues. This, too, is critical. We are in a national crisis. Right now, 48 percent of the children being born in Baltimore City are born out of wedlock. That is not a moral commentary, this is not a conversation related to the "scarlet A" of adolescent pregnancy. We are not talking that way. But we are saying that if women are to have a future, this program will most importantly be needed.

Governor Schaefer has just launched a program to deal with teenage pregnancy, needs Federal help, and I know throughout Baltimore right now they are wearing sweatshirts that just says "I'm not gonna mess around."

With that, I will yield back the time that I have.

Senator ADAMS. Thank you, Senator Mikulski.

Senator KASSEBAUM. It's hard to beat that observation, Mr. Chairman.

I would just say that I have always considered myself a mother before a Senator, so I am very sensitive to this issue. I have believed that family planning assistance is an important initiative, and that we must be sensitive to all its aspects, and deal with it in a constructive and thoughtful manner.

I look forward to hearing the witnesses, Mr. Chairman.

Senator ADAMS. Thank you, Senator.

Senator Coats?

Senator COATS. Thank you, Mr. Chairman.

I have a statement which I would like to submit for the record.

Senator ADAMS. Without objection, the statement will be included in the record.

Senator COATS. I will just briefly state that I have in the past several years had a number of concerns about Title X and the way it relates to how we provide family planning services.

I don't oppose the concept of family planning per use. I am concerned about four particular areas that have been the source of a great amount of debate and dissension and discussion within this Congress, the promotion of abortion and abortion-related activities, promotion of abortifacient research, school-based clinics which provide contraceptive and abortion services to adolescents in school settings, and continued barriers to adoption opportunities.

I would hope that we could use this process that we are going to through to address these concerns. I have a number of questions to ask and look forward to the testimony of the witnesses.

Thank you.

(The prepared statements of Senator Coats and Senator Metzenbaum follow:)

PREPARED STATEMENT OF SENATOR COATS

Senator COATS. Mr. Chairman, the Title X program has been the subject of great discussion over its 19-year history. That controversy, if anything, has heightened over the years, as increasing scrutiny has been placed on the program, and on the activities of program grantees.

I am unable to support Title X in its present form. This program has been administered, the evidence indicates, in a manner not consistent with original congressional intent, and to support the 4-year reauthorization of Title X now before us would be to perpetuate our error. This bill does not adequately address certain troubling concerns. And it even raises additional problems which beg for redress before they are permanently incorporated into the law.

My concerns, relating to both the program and its reauthorization, center around four areas—continued promotion of abortion and abortion related activities, continued promotion of abortifa-

cient research; promotion of school-based clinics which will provide contraceptive and abortion services to adolescents in school setting; and continued barriers to adoption opportunities.

The original intent of Congress was clear—to fund the availability of preventative family planning services. Section 1008 of the Title X statute states: "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."

The separation of abortion activities from family planning activities could not be put any more simply: Title X family planning programs may not include abortion.

Thus, section 1008 was intended to establish a wall of separation between pregnancy prevention and pregnancy termination services.

Despite the statutory restriction found in section 1008, Title X guidelines actually require abortion referral and "nondirective" abortion counseling as part of options counseling. This requirement stands in striking contrast to the statute, and it effectively prevents organizations intent on observing the wall of separation between abortion and family planning from receiving Title X money. This taints legitimate family planning methods, and erodes public confidence in the Nation's family planning program.

I think the Department's new regulations go a long way toward finally enforcing the Title X program as originally intended by Congress. I fully support these regulations as a long-awaited means to end abortion-related activities in the Title X program. The taint of abortion has only served to discredit the legitimate family planning activities that may be carried out under Title X. When we mark up S. 110 later this week, I hope we will respect the spirit and letter of those regulations.

Mr. Chairman, another concern related to this issue is the potential use of Title X funds to research and promote the development of abortion inducing drugs. Section 7 of S. 110 would provide grant money to public and nonprofit private entities in order to "enhance the work of the National Institute of Health. In applied contraceptive research and evaluation, and specifically to promote the development, marketing, and evaluation of new and improved contraceptive devices, drugs, and methods . . ."

A careful reading of section 7 will reveal it may authorize funding for research which is technically prohibited by Section 1008 of Title X of the Public Health Law. As I have noted, section 1008 clearly prohibit activities which would promote abortion, including the early abortions that are the object of some reproductive research.

RU–486 is not simply a contraceptive, and research into its modes of operation—whether prior to conception or following fertilizations not simply the promotion of contraception. This drug does not discriminate between a womb with an unborn child, and an empty uterus. It can and does induce abortion in the first trimester of pregnancy.

In conclusion, S. 110 does not attempt to remedy concerns about abortion and abortion related activities in the Title X family planning program, in fact, it exacerbates justified concerns by increasing funding that might promote research into the abortion pill. I cannot support S. 110 in its present form, and will support amend-

ments to ensure appropriate restrictions on funding to abortion providers, funding for activities that promote abortion, and funding for research into abortifacients.

PREPARED STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. Each year about this time, we begin the process of reauthorizing one of the most important Federal programs in existence—the family planning program. This program is literally saving lives. it is giving women a chance to control their own destiny. It is giving teenage girls from poor backgrounds a chance to go to school and make a life for themselves.

Yet, despite the enormous importance of this program, despite the vast benefits it brings, compared to its relatively modes cost, we all know that it will be difficult to pass a reauthorization bill. In all likelihood, we will end up appropriating money for this program but not passing an authorization, just as we have since the last authorization was enacted for fiscal year 1985.

Why? We know the answer. Abortion is a political football. It's a battleground where people who believe they have the right moral answers try to impose their views on others. Family planning is an inviting target for all sorts of mischievous abortion-related amendments. Its a playing field for abortion political football.

What makes this sad game amazing is that the use of family planning funds for abortion is strictly prohibited. No one can credibly claim these funds are used to pay for abortions. Instead, we hear nonsensical proposals to bar the use of family planning funds to pay for "counseling" for abortion. In other words, the staff of the clinic would be required to be unethical, to engage in medical malpractice, by refusing to give women information about their options. Another foolish idea is to prohibit use of funds if abortions are performed in the same facility. The impact of such an amendment would be to bar family planning programs in hospital outpatient clinics. Such a misguided amendment could have a disastrous impact in poor, urban areas where the only source of family planning services is a hospital.

Some day, I hope sooner rather than later, the American public may finally decide that abortion is a matter of individual choice. The Congress will quit taking time playing abortion political football. In the meantime, I believe the family planning program will survive under difficult circumstances performing a crucial service—giving women control over their lives.

Mr. Chairman, I commend you for holding this hearing and I urge prompt action on this legislation.

Senator ADAMS. Thank you, Senators.

We want to welcome all of the witnesses here today. We appreciate your time and the effort that you have given to be here and be present with us. It gives me a great deal of pleasure at this time to have as a witness Mrs. Nabers Cabaniss, who will address us.

Secretary Cabaniss, we welcome you to the committee and are prepared to hear your testimony.

Thank you. Please start.

STATEMENT OF NABERS CABANISS, DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mrs. CABANISS. Thank you, Senator.

Mr. Chairman and members of the committee, I am pleased to be here to discuss Title X of the Public Health Service Act, which is the national family planning program, and Title XX of the Public Health Service Act, the adolescent family life program.

In the interest of time today, I am going to summarize my written statement and try to condense it down to 5 minutes.

Senator ADAMS. Without objection, your entire statement will appear in the record as written.

Mrs. CABANISS. Thank you.

Family planning services are an integral component of primary health care and are well established in most States. The department strongly supports authorization of the Title X family planning program as a State-administered grant program and will soon submit legislation to bring this about.

The current Title X family planning statute authorizes four components: family planning services; research; training; information and education. In fiscal year 1989 a total of $138.3 million is being provided to support the Title X family planning program. Title X currently funds 88 grantees which provide services at over 4,000 clinic sites to an estimated 4.3 million women, about one-third of whom are adolescents.

The fiscal year 1990 budget request would maintain the fiscal year 1989 funding level. Family planning services in the United States are provided in private physicians' offices and in publicly and privately managed clinic settings. Funding for family planning is provided by a variety of different sources, including client fees, insurance, private donations, local and State funds, and funding from a variety of Federal programs, of which Title X is one.

Overall Federal expenditures for family planning have increased over the past 8 years. While Title X appropriation levels decreased about 20 percent between 1981 and the present, expenditures from the larger Medicaid family planning component nearly doubled over the same period.

In addition, family planning funding support continues to be provided by the maternal and child health block grant and the social services block grant programs.

Estimates from the bureau common reporting requirement system indicate that the number of clients served annually in Title X has remained at about 4 million over the past 8 years, and the proportion of those who are low income has increased from 75 percent to 85 percent over this period.

During the same time period, the nationwide number of low-income women in need of family planning services has decreased, primarily because of a decrease in the total number of women in their early reproductive years and an increased use of sterilization among women in their later reproductive years.

Thus, Title X today serves a higher proportion of the in-need population than it did in 1982.

Title X was enacted in 1970 as a national program to assist in making family planning services readily available to all persons desiring such services. Family planning projects are required to provide a broad range of acceptable and effective methods of contraception and various other services related to reproductive health care. Acceptance of family planning services must be voluntary.

Since the enactment of Title X, requirements have been added that natural family planning, infertility services, for adolescents, and family involvement must be a part of Title X projects. In accordance with the statute, programs funded by Title X must assure that priority is given to persons from low-income families.

Title X also contains an explicit prohibition on the use of funds appropriated under this title in programs where abortion is a method of family planning. In February 1988, the department promulgated new regulations to ensure grantee compliance with this prohibition.

We will soon be submitting legislation to establish Title X as a family planning grant program fully administered by the States. Shifting the administration of the program to the States will enable them to exercise maximum flexibility in tailoring services to meet their citizens' family planning needs more appropriately and effectively.

Within this framework, certain Federal requirements would be retained from current law, including the prohibition on funding programs where abortion is a method of family planning, priority for serving low-income families, encouragement of family participation, and the requirement that services be voluntary.

The proposed program of State-administered grants would have many advantages over the present grant program. It would result in improved allocation of resources, improved services delivery, and greater administration flexibility for the States.

It will allow States to plan family planning programs in conjunction with other State-administered health programs and the financially larger effort of the Medicaid program and thereby improve integration and coordination of services.

Service delivery and program administration would be improved by elimination of application, reporting, and monitoring requirements in the current program.

On February 2 of 1988, HHS issued regulations to clarify and enforce the statutory prohibition on the use of funds in programs where abortion is a method of family planning. Under these regulations, a Title X project may not include abortion as a method of family planning, may not provide counseling and referral for abortion, must maintain physical and financial separation from prohibited abortion activities, and may not engage in any activities which encourage or promote abortion as a method of family planning.

Since that time, we have been engaged in a variety of lawsuits and during the question-and-answer period I will be happy to fill you in on where we stand there.

Let me very briefly highlight our initiatives with respect to the adolescent family life program. As the chairman has stated, early sexual activity and the resulting problems of adolescent pregnancy continue to be serious concerns of the American people and this Administration. The AFL program is the only Federal program

specifically designed to address the problems of adolescent sexual activity and subsequent adolescent pregnancy.

Between 1971 and 1979, the proportion of sexually active girls age 15 to 19 increased from 27 to 39 percent. By 1982, the proportion had increased to 43 percent. The number is now increasing at a slower rate and appears to be leveling off. Of sexually active girls, about one million become pregnant annually. Of these pregnancies, 50 percent result in live births, 40 percent end in abortions and the remainder in miscarriages.

We are recommending that AFL program be authorized for three years at its current $9.5 million funding level. Reauthorization of the existing program will allow some currently funded programs to complete their projects and evaluations and a number of new projects to be initiated.

To very briefly highlight the focus of the current AFL program, it was enacted in 1981 to support the development of new and innovative approaches to preventing teen pregnancy and to providing services, in many ways alternatives to abortion services to pregnant teens. The AFL program encourages sexual abstinence for teens and family involvement in service delivery.

It funds model demonstration projects which provide social, educational, and health services to teenagers, pregnant and parenting teens, and emphasizes the importance of the family in resolving the complex problems of teen pregnancy. The program requires parental consent for services, promotes adoption as a positive option for unmarried teens, has no involvement in abortion, and addresses the issue of sexuality in the context of marriage by encouraging unmarried teens to postpone sexual activity.

We are pleased with the findings from some AFL demonstration projects. We have found that some comprehensive care programs can have a significant effect in improving the outcomes for pregnant and parenting teens and her infants. In addition, data show that AFL prevention projects can change attitudes and values in ways which result in reduced likelihood of teens engaging in early sexual activity. The changes include improved parent-teen communication about sexual matters and improved teen attitudes toward the desirability of postponing early sexual activity.

Mr. Chairman, we urge you and your colleagues to join the Administration in supporting our legislation to facilitate the delivery of improved and better-coordinated family planning services within a State-administered family planning program and to support our legislation to extend the existing adolescent family life program for 3 years at current funding levels.

Thank you for the opportunity to testify here today, and I will be happy to answer any questions you may have.

[The prepared statement of Mrs. Cabaniss follows:]

PREPARED STATEMENT OF NABERS CABANISS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I am pleased to be here today to discuss Title X of the Public Health Service Act, the national family planning program, and Title XX of the Public Health Service Act, the Adolescent Family Life Program. Both programs are administered by the Public Health Service's Office of Population Affairs.

Family planning services are an integral component of primary health care and are well established in most States. The Department strongly supports authorization of the Title X family planning program as a State administered grant program and will soon submit legislation to bring this change about. Making the States the sole family planning grantees will enable them to exercise maximum flexibility in tailoring services to best meet their citizens' needs. States and territorial health departments are the sole grantees in 26 States and 7 territories, and in another 11 States they are one of the grantees funded by the program. Enactment of our proposal would allow States to administer the family planning program in all jurisdictions, with the flexibility to operate clinics through county agencies, private agencies, or hospitals as is most appropriate for each particular State.

The current Title X family planning statute authorizes four components: family planning services, research, training, and

information and education. In fiscal year 1989, a total of $138.3 million is being provided to support the Title X family planning program. Title X currently funds 88 grantees which provide services at over 4,000 clinic sites to an estimated 4.3 million women (about one-third of whom are adolescents). In addition to the funds for family planning services, estimated funding for the three other major program areas is $1.8 million to support the research program designed to improve the delivery of family planning services, $3.2 million to provide training for family planning personnel, and $300,000 to fund information and education activities. The fiscal year 1990 budget request would maintain the fiscal year 1989 funding level.

Family planning services in the United States are provided in private physicians' offices and in publicly and privately managed clinic settings. Funding for family planning is provided by client fees, insurance, private donations, local and State funds, and funding from a variety of Federal programs, of which Title X is one.

Overall Federal expenditures for family planning have increased over the past eight years. While Title X appropriation levels decreased about 20 percent between 1981 and the present, expenditures from the larger Medicaid family planning component nearly doubled over this same period. In addition, family planning funding support continues to be provided by the Maternal

and Child Health Block Grant and the Social Services Block Grant programs.

Estimates from the Bureau Common Reporting Requirements (BCRR) system indicate that the number of clients served annually in Title X settings has remained at about 4 million over most of the past eight years, and the proportion of these who are low-income has increased from 75 percent to 85 percent over this period. During this same period, the nationwide number of low-income women in need of family planning services has decreased, primarily because of a decrease in the total number of women in their early reproductive years, and an increased use of sterilization among women in their later reproductive years. Thus, Title X today serves a higher proportion of the in-need population than it did in 1982.

Family Planning Services

Title X was enacted in 1970 as a national program to assist in making "family planning services readily available to all persons desiring such services." Family planning projects are required to provide a broad range of acceptable and effective methods of contraception and various other services related to reproductive health care. Acceptance of family planning services must be voluntary. Since the enactment of Title X, requirements have been added that natural family planning, infertility services,

services for adolescents, and family involvement must be a part of Title X projects. In accordance with the statute, programs funded by Title X must assure that priority is given to persons from low-income families. Title X contains an explicit prohibition on use of funds appropriated under this title in programs where abortion is a method of family planning. In February 1988, the Department promulgated new regulations to ensure grantee compliance with this prohibition.

To support the delivery of family planning services, grants are awarded to public and private non-profit entities to establish and operate voluntary family planning projects. These grants are awarded and monitored by the Public Health Service regional offices.

Included in the fiscal year 1989 service funds allocated to each regional office was $500,000 to support National Priority projects in the areas of infertility services, family involvement, male involvement, adolescent abstinence, prevention of sexually transmitted diseases (including HIV infection), and regionally determined areas of concern.

Service Delivery Improvement Research

The focus of the Service Delivery Improvement Research Program continues to be the enhancement of the delivery system,

particularly at the clinic level. Currently funded service delivery improvement projects include projects to study the effects of integrating family planning services with other services such as primary care, factors influencing contraceptive behavior among adolescent clients, ways in which clinics can attract more male clients, and other related family planning issues.

An agreement is being continued between the Office of Population Affairs (OPA) and the National Institutes of Health (NIH) to provide peer review of all service delivery improvement research grant applications. This process insures the selection of projects which are of high technical quality and are directed to high priority research questions within the family planning field.

To insure that service providers, researchers, and policymakers have access to research findings, all service delivery improvement research grantees are required to deposit their data in a public use data archive. This facilitates not only wide availability of the study results, but also insures that the data upon which the conclusions were based are accessible. Findings from completed projects have been published in such journals as Family Planning Perspectives, American Journal of Public Health, and Family Relations.

Training and Informational Activities

Title X training programs are designed to provide personnel with skills and knowledge necessary for the effective delivery of family planning services. Training is currently provided through ten regional general training grants and five nurse practitioner training grants. These grants provide training for personnel at all levels of services delivery including medical and professional staff, administrators, and technical and clerical staff. In fiscal year 1988, through an Interagency Agreement with the Centers for Disease Control, each of the training grantees was awarded supplemental funds to provide training on the prevention of AIDS. Support is also continuing for the development of a broad range of family planning information and educational materials. Under the law, informational and educational materials used in Title X projects must be suitable for the community and population for which they are used.

1990 State Administered Family Planning Program Proposal

We will be submitting legislation to establish Title X as a family planning grant program fully administered by the States. Shifting the administration of the family planning grant program to the States will enable them to exercise maximum flexibility in tailoring services to meet their citizens' family planning needs more appropriately and effectively. Within this framework,

certain Federal requirements would be retained from current law, including the prohibition on funding programs where abortion is a method of family planning, priority for serving low-income families, encouragement of family participation, and the requirement that services be voluntary.

The proposed program of State administered grants would have many advantages over the present grant program. It would result in improved allocation of resources, improved services delivery and greater administrative flexibility for the States. This proposal will allow States to plan family planning programs in conjunction with other State-administered health programs and the financially larger effort of the Medicaid program and thereby improve integration and coordination of services. Service delivery and program administration would be improved by elimination of application, reporting and monitoring requirements in the current program.

The Title X family planning program plays an important role in the health care system by providing a needed service to over 4 million persons, primarily low-income women, each year. We believe our proposal to shift administration of the program to the States will provide States with the necessary authority and flexibility and responsibility to improve the efficiency and effectiveness of the program. This action will increase the program's ability to meet the health care needs of our citizens

and improve the delivery of high quality, free or low cost family planning services to the people who need these services.

Regulations Prohibiting Abortion as a Method of Family Planning

On February 2, 1988, the Department of Health and Human Services issued final regulations to clarify and enforce the statutory prohibition on the use of funds in programs where abortion is a method of family planning. The rules apply only to Title X projects; the rules do not govern activities that are not part of the Title X project. Under the regulations, a Title X project (a) may not include abortion as a method of family planning, (b) may not provide counseling and referral for abortion, (c) must maintain physical and financial separation from prohibited abortion activities, and (d) may not engage in any activities that encourage or promote abortion as a method of family planning.

Four separate lawsuits have been filed challenging the statutory and constitutional bases of the new Title X regulations. Three of these cases (filed in Denver, Boston, and New York) are now pending in their various Circuit Courts of Appeals and we are awaiting Court action in these cases. The Department is currently enjoined from enforcing the regulations with respect to certain grantees under two separate permanent injunctions entered in the Boston and Denver cases. Those injunctions cover members

of the National Family Planning and Reproductive Health Association, Inc. (NFPRHA), and the Planned Parenthood Federation of America, Inc., among others.

In the New York case, the District Court issued an order dismissing the lawsuits filed by the American Civil Liberties Union (ACLU), the State of New York and other plaintiffs finding that the regulations are within the Secretary's authority under Title X and are constitutional. Plaintiffs did not seek a stay in this case, and the Department is not enjoined from implementing the regulations with respect to Title X grantees represented in this case.

In a fourth suit, subgrantees in the State of West Virginia recently filed suit challenging the implementation of the regulations in that State. The State of West Virginia has joined that suit. The case is currently before the District Court in West Virginia.

It has been and continues to be the Department's position that except where enjoined from enforcing the regulations, we are, where practicable, proceeding to implement the regulations at the time grant awards are made. All grant applicants are required to provide certification as to whether they are or are not covered by one of the court injunctions. We are examining difficult implementation situations on a case-by-case basis.

Title XX Adolescent Family Life Program

I would also like to discuss the Adolescent Family Life (AFL) Program authorization under Title XX of the Public Health Service Act. Early sexual activity and the resulting problem of adolescent pregnancy continue to be serious concerns of the Administration. The AFL program is the only Federal program specifically designed to address the problems of adolescent sexual activity and subsequent adolescent pregnancy. Between 1971 and 1979, the proportion of sexually active adolescent girls aged 15-19 increased from 27 to 39 percent. By 1982, this proportion had increased to 43 percent. Although it is still increasing, the number is increasing at a slower rate and appears to be leveling off. Among sexually active girls, approximately one million have became pregnant annually. Of these pregnancies, 50 percent result in live births, 40 percent end in abortions and the remainder result in miscarriages or stillbirths.

We believe that there is a Federal role in supporting this demonstration and research program and encouraging States and communities to implement new and innovative approaches that have been developed and tested by AFL grantees to address the problems of teenage sexuality. Therefore, we are recommending that the Adolescent Family Life Program be reauthorized for three years at its current ($9.5 million) funding level. Reauthorization of the existing AFL program will allow some currently funded programs to

complete their projects and final evaluations and a number of new projects to be initiated. Through this program the knowledge base for the most effective approaches to the problem will be expanded.

The AFL program estimates that it will support 66 demonstration programs and 14 research projects during fiscal year 1989. These projects are located in urban and rural settings across the States and the territories. New demonstration applications for 1989 are now being processed for review. Approximately $2 million will be available for about 16 new projects. Approximately $700,000 will be available to support 7 new research projects.

The AFL Approach

The AFL program was enacted by Congress in 1981 to support the development of new and innovative approaches toward preventing adolescent pregnancy and providing services to pregnant teenagers and to fund research to study the underlying causes of the problem. The AFL demonstration program, which encourages sexual abstinence and family involvement in service delivery, was established to develop model services projects. These projects provide social, educational and health services to teenagers, pregnant teens, and parenting teens, and emphasize the importance of family in resolving the complex problems of teenage pregnancy.

The program requires parental consent for services, promotes adoption as a positive option for unmarried pregnant teens and addresses the issue of sexuality in the context of marriage by encouraging unmarried teens to postpone sexual activity. The program has two major components, (1) demonstration projects offering care or prevention services and (2) research projects to build the knowledge base necessary to address the problem of adolescent pregnancy effectively.

Care Projects

The purpose of care projects is to establish innovative, comprehensive and integrated approaches to the delivery of care services for pregnant adolescents under 19 years of age, with primary emphasis on unmarried adolescents who are 17 years old or younger and their families. This includes young fathers and their families. Projects are required to develop approaches which strengthen family commitment, address the underlying problems that lead adolescents into out-of-wedlock pregnancy, and offer innovative approaches to presenting adoption as an option for adolescent parents. AFL care projects insure that each pregnant adolescent receiving services is provided with counseling and information to help her decide whether to raise the child herself or make an adoption plan. All AFL grantees offering care services provide adoption counseling and referral to licensed adoption agencies for pregnant adolescents who

request these services. Comprehensive services are available to the pregnant adolescent whatever her decision regarding parenting or adoption plans. Services are tailored to the needs of each adolescent depending upon her plan and continue after the birth of her baby.

Care services are provided through a variety of agencies, both public and private. In a rural community in the Northwest, for example, services are provided through a private rural health clinic with extensive home visiting by service providers. In urban settings, services have been provided in low-income housing projects through local community centers. Services have also been located in large metropolitan hospitals and in smaller community hospitals. Adoption agencies providing comprehensive services to pregnant teens have also received AFL funding. Projects located in or near public schools have also provided comprehensive AFL services, including on-site day care so that teen mothers can finish their education. In one community, a unique project contracted with local physicians to provide both pre- and post-natal health care in their offices while social and educational services were provided at the project site.

Prevention Projects

The purpose of the prevention programs is to find an effective means within the context of the family to reach adolescents, both male and female, before they become sexually active in order to maximize the guidance and support available to adolescents from parents and other family members in promoting abstinence from adolescent premarital sexual relations. Developing new and innovative approaches to family life educational services that clearly and unequivocally promote abstinence among unmarried adolescents is the primary goal of AFL projects offering prevention services.

Prevention projects offer a range of activities to encourage abstinence and to assist teens and their parents to communicate better about responsible sexual behavior and other matters pertaining to sexuality, marriage and the family. One project has provided parents with parenting and communication skills to assist them in communicating with their children on sexuality and also has educated community leaders and other community members on the consequences of adolescent sexual activity. Another program based on informing parents about child development and improving communication skills has been carried out during employee lunch hours. Another project has trained school counselors from public schools throughout the county to implement a prevention curriculum for parents and their children which has reached thousands of families. A well known national

organization has used volunteers to implement an educational program for pre-adolescents and their parents in public schools.

Evaluation

Title XX requires that each demonstration project establish a working relationship with an independent evaluator from a college or university in its State to conduct an evaluation of project services. All demonstration projects are required to have an evaluation component of high quality consistent with the scope of the proposed project and the funding. Title XX requires that each project expend at least one percent but not more than five percent of the funds received under Title XX for evaluation purposes.

We have been pleased with the findings from some AFL demonstration projects. AFL evaluations have found evidence that some comprehensive care programs can have a significant effect in improving the outcomes for a pregnant or parenting teen and her infant. In addition, evaluation data have shown that AFL prevention projects can change attitudes and values in ways which result in reduced likelihood of teens engaging in early sexual activity. Among the changes are improved teen-parent communication about sexual matters and values and changed teen attitudes about the desirability and wisdom of engaging in early sexual activity.

For instance, a cross-site analysis of several care sites which reported low birthweight information and which have appropriate comparison populations, found a lower incidence of low birthweight among teens who participated in the program than in the comparison group. In a similar analysis, sites which reported educational outcomes showed significant success in returning participants to school when compared to the comparison population. A preliminary report from a study of adoption components of AFL care projects provides some insight on which factors appear to affect the decision of teens to decide to make an adoption plan.

In order to enhance strong evaluations that focus on outcome variables consistent with the key purposes of Title XX, in the fiscal year 1989 round of grant application competition, the OPA has announced that we will consider waiving the five percent limit on spending for project evaluations to allow up to 30 percent for applications which propose evaluation-intensive projects. We hope that such evaluations will enable other private and public service providers to adopt effective approaches in their own communities.

Information Dissemination Activities

The AFL program is engaged in dissemination activities as the results of research and demonstration projects are becoming available. Since demonstration projects are three- to five-year programs and the first round of projects was funded in September 1982, we are compiling data from completed projects. To assist counselors in presenting adoption as a positive alternative to unmarried pregnant adolescents, the OPA has developed and disseminated The Adoption Option: A Guidebook for Pregnancy Counselors. OPA also has developed and disseminated over 2 million copies of the brochure Many Teens are Saying "No," a short pamphlet that provides good information and clear guidance about abstinence without lecturing to teenagers. We are also in the process of developing the 1988 Update to the Summary of AFL Demonstration Projects, which provides short, readable information about all AFL demonstration projects and which will be available very shortly for public dissemination.

The AFL Data Archive on Adolescent Pregnancy and Pregnancy Prevention was created in 1982 to provide the public with access to the data that were often not available directly from the research community and to play a role in encouraging additional research on adolescent pregnancy. The Archive accepts public use data tapes from AFL research grantees who are required to deposit their data within 18 months following the completion of their study. The Archive identifies data sets which are useful for

studying adolescent pregnancy, acquires them, prepares standardized documentation, sells the data sets to researchers at cost, and assists researchers in analyzing the data. As the holdings of the Archive grow, it will come to have a major role in facilitating the work of the adolescent pregnancy research community.

AFL Research

To maximize its contribution to the knowledge base about teen pregnancy, AFL has concentrated its efforts on some specific problem areas, such as: the determinants and consequences of premarital adolescent sexual relations; behavior patterns during the adolescent pregnancy, especially the decision to raise the baby herself or make an adoption plan; and the effects of care services on the outcome of pregnancy and the subsequent development of the adolescent and her infant.

Mr. Chairman, we urge you and your colleagues to join the Administration in supporting our legislation to facilitate the delivery of improved and better coordinated family planning services within a State Administered Family Planning Program, and to extend the existing Adolescent Family Life program for three years at current funding levels.

Thank you for the opportunity to testify today. I will be happy to answer any questions that you may have.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

The Honorable Brock Adams
U.S. Senate
Washington, D.C. 20510

MAY 10 198

Dear Senator Adams:

I understand that following my testimony yesterday and after I had left the hearing room, substantial discussion took place about the quality of the data I had cited relating to the decrease in the number of low-income women at risk of unintended pregnancy. I want to make sure that you receive the facts.

The statistics I mentioned were not HHS data, but rather were derived directly from a recent publication of the Alan Guttmacher Institute (AGI), **Women at Risk: The Need for Family Planning Services, State and County Estimates, 1987.** I have enclosed the introduction to that report for your information, but let me quote a few of its findings.

With regard to trends in the numbers of low-income women at risk of unintended pregnancy, the report states,

> "The number of low-income women at risk fell by 16 percent, from 9.5 million in 1981 to 7.9 million in 1987, and the target group of women in need, those at risk aged 20-44 under 200 percent of poverty and all teenagers at risk, fell 17 percent...
>
> "The principal factors that contributed to the change in the estimated number of women in need were changes in the size of the population, the proportion of the population with a low-income, the percentage of unmarried women who are sexually active and the percentage of married couples who are infecund."

In a discussion of trends in the numbers and distribution of all low-income women, the report states,

> "While the population of women aged 13-44 increased seven percent, the number of low-income women (under 150 percent of the poverty level) fell by nine percent....

> "Region I, the New England States, experienced a 37 percent decline in the number of poor women, while Region VI, which includes Texas, had an increase of 12 percent. Region X also had an increase (four percent), and the remaining regions had decreases ranging from one percent (Region VIII) to 23 percent (Region II)."
>
> (All quotations from Introduction, p. x)

While I am submitting written responses to Committee questions for the hearing record, I particularly wanted to make sure that this information came to your personal attention.

If I can be of additional assistance on these matters, please let me know.

Sincerely,

Nabers Cabaniss

Nabers Cabaniss
Deputy Assistant Secretary
for Population Affairs

Enclosure

Senator ADAMS. Thank you, Secretary Cabaniss.

In light of yesterday's court decision ruling that the department's regulations were unconstitutional with regard to the prohibition on abortion counseling, is there any purpose served in continuing to enforce regulations against grantees not directly covered by the ruling?

Mrs. CABANISS. Mr. Chairman, when the regulations were issued, suits were filed simultaneously in three different districts: the one in Boston which you are referring to, representing members of NFPRHA; the other in Denver representing members of the Planned Parenthood Federation and its affiliates; and the other was by the American Civil Liberties Union and the State of New York.

In two of those cases, the plaintiffs have prevailed in the litigation; specifically, the latest ruling was in the appellate court in Boston. In the other case, the department prevailed; that is in the case with respect to the ACLU in New York.

We are reviewing the ruling that was handed down yesterday, and we cannot at this point tell you whether it will affect ultimately our implementation strategy. But obviously the position of the department has been we will not implement where we cannot do so, but we have taken the position that we believe it important enough to separate abortion from family planning that we have continued to implement where legally entitled to do so.

Senator ADAMS. All right.

Senator Hatch?

Senator HATCH. Madam Secretary, do you support the provision of family planning services for minors without their parents' permission?

Mrs. CABANISS. Senator, that issue has certainly been one of the major controversies surrounding Title X, and it is frankly one of the big reasons for our support for State-administered family planning programs. I have serious concerns about the merits of providing family planning services, particularly prescription drugs and devices, with parents being essentially prohibited from knowing unless their child chooses to tell them that they have received such services.

Under the State-administered program, States would be allowed to apply their own State laws with respect to parental notification or parental consent.

Senator HATCH. Do you allow grantees to provide family planning services to teens without parental involvement?

Mrs. CABANISS. The statute requires that services to adolescents be provided. It also requires family involvement. As you know, back in 1982 we issued regulations to prohibit—excuse me, to require that prescription drugs and devices be provided only when parents are notified within 10 days. Those regulations were not upheld in the court.

Senator HATCH. OK. In your statement you note that you provide "various other services" in the family planning projects. Do you require that patients be tested for AIDS as a part of the routine physical?

Mrs. CABANISS. Our projects are not required to test for AIDS. They are required to provide prevention education and to do some

sort of risk assessment relating to which of their clients are most at risk of HIV. But as you know, this is going to be a growing problem for our family planning clinics who are more and more faced not just with the issue of preventing teen pregnancy but with how do we both prevent pregnancy and prevent disease transmission. Increasing numbers of our clients are coming in infected with chlamydia, syphilis, gonorrhea, and of course the AIDS problem is a growing one.

The method of choice for contraception among adolescents is primarily the oral contraceptive, and the oral contraceptive does nothing to protect against disease prevention.

So, that is obviously a very big concern of ours. A Title X project may test for AIDS, but it is not required to.

Senator HATCH. Mr. Chairman, I have other questions, but I will submit them in writing.

Senator ADAMS. Thank you, Senator Hatch.

Senator Mikulski?

Senator MIKULSKI. Thank you, Senator.

Before I ask our deputy assistant secretary some questions, I would like to ask unanimous consent that the description of the Laurence G. Paquin School and all of its services be entered into the record so we could have just a description of what one of the programs are.

Senator ADAMS. Without objection, it is so ordered and it will be entered in the record.

[The Laurence G. Paquin School brochure follows:]

A Baltimore City Public High School
that provides
a complete educational program
with
an emphasis on prenatal, parenting
and preschool program for both
teenage mother and child.

Paquin School 8457 Takes Pride in Parenting.

2200 Sinclair Lane
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LAURENCE G PAQUIN SCHOOL

LAURENCE G PAQUIN SCHOOL

It's more than just Academics ...
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for Expectant Teenage Mothers

LAURENCE G. PAQUIN SCHOOL

The Laurence G. Paquin School is a comprehensive high school and is perhaps the largest, among the newest, and certainly one of the most beautiful public schools for expectant adolescent mothers in the United States. Each year, the program serves over 1,000 students between the ages of eleven to twenty.

Since 1966, the program continues to offer the most comprehensive and dynamic prenatal and parenting programs for young mothers. Additionally, the on-site infant-toddler center adds a special feature to the program. The center serves as an observatory, practicum, resource and demonstration center for all enrolled students, their parents, outside agencies, and concerned professionals.

PAQUIN TAKES PRIDE IN PARENTING with a dedicated staff in order that the young mother becomes the best parent for her baby.

SUPPORT SERVICES

1. Health Facility Suite and Services
2. Guidance and Counseling
3. Career Social Services Counselling Services

SPECIAL PROGRAMS

1. Family Life
2. Prenatal and Parenting
3. Preschool Curriculum
4. Infant-Toddler Center

THE ADOLESCENT FAMILY LIFE PROGRAMS AND SERVICES OFFICE

1. Training programs for professionals and parents.
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3. A parenting and toy lending library consisting of effective learning toys and parenting education films and slides.
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THE REALITY OF A GOOD EDUCATION

The history of women in our American society is tainted with deprivation and oppression. In the seventeenth century, it was said that girls need "only sufficient geography to find their way around the house and enough chemistry to keep the pot boiling."

In 1872, the Supreme Court issued the following prescription for women: "The natural and proper timidity and delicacy which belongs to the female sex unfits it for many of the occupations of civil life." In the early nineteenth century, it was almost impossible for women to get any education. Schools accepted girls only in the summer, when classrooms were vacated by boys needed on family farms. A girl's curriculum consisted of handwriting, drawing, embroidery, music, dancing, a little French, and some religious reading. For decades, educators, doctors, and the general public debated whether women were strong enough to withstand the rigors of a college education.

With such a history, we as women need to ask ourselves, "how far have we come — how far do we still have to go if we are to become fully qualified to participate in the occupations necessary for civil life?" One of the most powerful tools for assuring that all females receive the same opportunities that are offered to their male counterparts was the Educational Amendment of 1972 (Title IX). In short, this legislation prohibits discrimination on the basis of sex in educational institutions that receive any federal funds.

Education for the female has progressed a great deal since 1980. You are a part of this progress, in that you are permitted to continue your education while preparing for motherhood. Unlike your predecessors, you have an opportunity that was not afforded to them — the right to a good education.

Remember, the learning process never stops; the reality of a good education is here, make the women of yesterday proud, make the women of tomorrow envious of your achievements! The time for a good education is here — take advantage of it wherever you go.

THE LAURENCE G. PAQUIN SCHOOL

The Laurence G. Paquin School is a comprehensive high school and is perhaps the largest, among the newest, and certainly one of the most beautiful public schools for expectant adolescent mothers in the United States. Each year, the program serves over 1,000 students between the ages of eleven to twenty.

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PAQUIN TAKES PRIDE IN PARENTING with a dedicated staff in order that the young mother becomes the best parent for her baby.

MISSION STATEMENT

The mission of **PAQUIN** is to provide expectant teenagers the opportunity to continue or complete their education in an institution that is designed to meet their needs. **THE PAQUIN SCHOOL** enables students to receive a personalized, intensive educational experience guided by an experienced and dedicated staff who understands, nurtures and cares for the young mothers. The informality and relatively small classes enable instructors to assist young women with their personal development, to build their self-esteem, to strengthen academic weaknesses, to make realistic career choices, and to develop job skills which alleviates much of the stress and depression that accompanies an unplanned pregnancy. **PAQUIN** is a very special place where a sympathetic and cheerful environment inspires students to raise their goals

SPECIAL PROGRAMS

1. **Family Life**
2. **Prenatal and Parenting**
3. **Preschool Curriculum**
4. **Infant-Toddler Center**

FAMILY LIFE AND PARENTING

The **FAMILY LIFE AND PARENTING DEPARTMENT** has developed its program to meet the needs of the time, and has incorporated new and better ways of providing useful services in units of study related to the expectant teenage mother.

The varied curriculum is offered to each young lady in the school. The exposure to its many facets includes units of study in prenatal care, human reproduction, labor and delivery, contraception, sexually-transmitted diseases, child care, growth and development of children, and non-traditional family problems. This type of curriculum offering allows student's needs to be met through individualized instruction, small group work, independent study and special assignments. In addition to teacher-directed lessons, community resource facilitators supplement the basic program. The program also contributes to the emotional, social and physical development of the expectant mother.

THE PRESCHOOL CURRICULUM

The **PRESCHOOL CURRICULUM** is designed to help the young mother meet the challenge of good care for the infant or preschooler, to foster independency by helping the child to learn self-care in the warm,nurturing atmosphere that is necessary to accommodate the child's dependency needs. Play activities provides emotional and social outlets and serve as a learning medium in a safe and stimulating environment. The program is an extended activity for the unit and projects a practicum for the class.

THE PAQUIN INFANT-TODDLER PARENT CENTER WHAT IS IT?

The Paquin Infant-Toddler Parent Center provides an exciting stimulation program for both infant and mother. The program has two components: an infant stimulation/learning program designed to promote an adaptive cognitive style, and an effective parenting program designed especially for the young mother. Thus, each young mother enrolled in the center is exposed to effective parenting techniques, as well as enhancing her chances of successful high school continuance and/or graduation.

When the mothers are in class, their babies are involved in a program designed to promote their effective skills and cognitive development, as well as to provide opportunities for perceptual motor and social development. To ensure that the babies develop the emotional and physical security which are prerequisites for learning, the center has a certified early childhood teacher and five (5) trained educational assistants. Three (3) infants are assigned to each assistant, providing spaces for fifteen (15) infants. These assistants, under the guidance and supervision of the teacher, provide the infant's primary care and stimulation. This educational assistant (caregiver) remains the same as long as the child is in the center.

THE PROGRAM

The primacy of the mother-child relationship is promoted and supported. Each day, the mothers have lunch and a scheduled class period with the teacher. To assist the mother with the stimulation of her infant's mental development, the following concepts are stressed with each mother:

1. Verbalization
2. Identification of relevant features
3. Imitation
4. Pleasure in task
5. A sense of efficacy
6. Cause and effect
7. Sensory experiences
8. Rich and varied experiences.

The teacher utilizes the total environment: toys, books, records, large muscle equipment, outdoor activities, and appropriate trips with mother and child. The parent education component focuses upon the basic areas of child development, infant learning and stimulation, care and management of the normal child, nutrition, health safety, family planning management and use of community resources. Daily parental interaction with the child is built into the program. Many opportunities are available to develop "adult-coping" skills, as well as parenting skills.

Health and nutrition are studied as they relate both to the needs of the parent and the child. Regular open-ended sessions (spontaneous and scheduled) are held daily to discuss the "every-day concerns" of the adolescent mother. These range from teen-parent conflict to rejection by the father of the baby. Community experts are frequent speakers. One credit is granted for each year of enrollment in the required course.

Parent education is also a responsibility of the five (5) educational assistants working within the center. They play a key role in this program because, as members of the local community and as the babies' primary caregivers, they are frequently the first people the student learns to trust. It is often the educational assistant to whom the parents turn with problems of health, housing and inter-family relationships. The teacher is always consulted to ensure that the educational assistants are dispensing correct information.

WHAT DOES THE CENTER DO FOR THOSE STUDENTS NOT ENROLLED IN THE CENTER?

The center enhances the Family Life and Parenting Program at Paquin in the following ways:

Observatory

- Reinforces parenting concepts, and provides an opportunity to observe visual growth patterns and behavior (expected/abnormal)

Practicum

- Students are able to practice vital parenting skills (i.e. how to bathe a baby).

Demonstration Center

- The center serves as an excellent resource centers for other schools and agencies who are in need of the hands on approach to parenting for the young mother.

CLOTHING AND ENTREPRENEURAL COMPONENT

The Entrepreneural Component of the Family Life and Parenting Department was developed to meet the needs of the adolescent parent or expectant mother with an actual work experience. Young mothers learn industrialized skills using both the industrial and home sewing machines. Utilizing basic skills previously learned, young mothers are able to produce simple garments and gift items, as well as children and maternity wear. As a result of this experience, young mothers will be job ready and prepared for employment at the industrial level and/or self-employment.

SUPPORT SERVICES:

HEALTH SUITE

Each student enrolled in this program will be encouraged to have prenatal care on a regular basis. We believe this to be such a significant component that we verify all medical appointments to ensure consistency in care.

We relate to physical, emotional and social problems on an individual and group basis. Students are encouraged to utilize the professional services offered in the Health Suite. We encourage our students to practice healthful living. They are provided knowledge of self during pregnancy and after they have delivered, students are also provided with adjusting and coping skills related to their physical changes.

Students are taught to understand their physiology and that of their babies'.

At the completion of a student's stay at the Paquin School, the students will have gained improved knowledge of their general health, human sexuality, and family planning.

The nurse prearranges tours and training programs on the concerns, needs, and problems of pregnant adolescents.

GUIDANCE AND COUNSELING

The GUIDANCE AND COUNSELING DEPARTMENT assists students in the development of life skills satisfying to self and acceptable to society. Students are provided with direction in resolving conflicts, solving problems, and planning educational needs in a logical progression. They are also guided in identifying interests, strengths, and weaknesses. They learn techniques to assist them in capitalizing upon their strengths and develop methods of overcoming their weaknesses.

The program is a continuation of the educational requirements in which students have been involved prior to entry at Paquin.

At the completion of their stay at Paquin, students are expectad to have an improved understanding of themselves and their needs. Students are also expected to accept and adjust to their new role as a student/parent, while at the same time, to focus on career goals and salable skills for gainful employment.

MEDIA SERVICES

The MEDIA CENTER is an integral part of the school's educational and support services and is designed to meet the varying needs of students, staff, and support persons through a variety of print and non-print material. The MEDIA CENTER also assists in the production, organization, and effective utilization of materials.

THE ADOLESCENT FAMILY LIFE PROGRAMS AND SERVICES OFFICE

This office provides a network of coordinated preventive and interventive educational, medical, and social services for Baltimore City's school-aged parents and the families.

As a training center, the office makes available to the public the following:

1. Training programs for professionals and parents.
2. A demonstration and resource center for professionals and parents.
3. A parenting and toy lending library consisting of effective learning toys and parenting education films and slides.
4. A research and data center.

SOCIAL SERVICES

Paquin's school social worker provides a variety of services to assist students with the difficult tasks of being both adolescent and pregnant or parenting. Individual counseling is made available regularly for personal problems or help in obtaining needed services; groups are scheduled for support, discussion and information; and workshops and assemblies provide speakers from the community who offer the students information on such topics as prepared childbirth, parent-child communication youth employment and training, and child abuse prevention. A peer counseling program has been developed by students to provide support, tutoring and friendship.

LAURENCE G PAQUIN SCHOOL

Senator MIKULSKI. Mrs. Cabaniss, I would like to come back to the court ruling yesterday, and I know you are reviewing it.

Do you plan, do you know if you or the department plans to pursue this decision at the circuit court level and then pursue an appeal process on this?

Mrs. CABANISS. We can't comment at this point. The Department of Health and Human Services must work with the Justice Department on whatever appeals procedures occur, and we have not yet had a chance to talk with them about yesterday's ruling.

Senator MIKULSKI. Well, you have had some rulings in some other cases. I understand two out of three court decisions have found these regulations to be unconstitutional.

Mrs. CABANISS. That's right. There have been three challenges, and the plaintiffs prevailed in two and we prevailed in the third.

Senator MIKULSKI. So you have had a chance to review the first two.

Mrs. CABANISS. Yes. And based on that review, we did decide to proceed with implementing the regulations wherever we were legally so entitled to do.

Senator MIKULSKI. So we have to wait now until the next step to hear what HHS and Justice decide?

Mrs. CABANISS. That's right.

Senator MIKULSKI. Is that right?

Mrs. CABANISS. Yes.

Senator MIKULSKI. In your testimony you talk about how the Administration proposes to shift the administration of family planning to the States. As I understand it, 22 States are not now primary Title X grantees. How would you go about that, and if they don't want to be the primary grantee, what would you do?

Mrs. CABANISS. Well, under the State-administered approach, the money would go directly to the States and then the States could distribute the money in any way they chose. Some, for example, particularly in the South, would probably be expected to use the network of county health departments for delivering services, as they do now. Others would perhaps use private nonprofit agencies or hospitals. It would be entirely up to the States to decide how they allocated the funds as long as they are being spent for family planning services.

Senator MIKULSKI. But you have 22 that didn't want to be a primary grantee. You had 22 States that don't want to be primary grantees. Where does this fit into this?

Mrs. CABANISS. I know that a number of States opposed many of the initial block grant proposals, but when it came down to a choice of whether or not to receive the funds, they chose to receive the funds. So I frankly, because most States do have their own family planning programs, I am hard-pressed to believe that they would not accept family planning funds.

Senator MIKULSKI. Well, I think only time will tell. But it strikes me as strange that if they had those family planning funds to begin with and are not primary grantees now, why they suddenly would feel they would want it.

Have they asked you to be?

Mrs. CABANISS. Some States have not applied. Any State Government is eligible to apply. Some don't apply and prefer that the

money go to a private nonprofit. Others have applied and not succeeded in getting a grant through the competitive process.

Senator MIKULSKI. Have you had a chance to talk about your particular department's mission with Dr. Sullivan?

Mrs. CABANISS. Personally, I have not spent a long time talking with him about it.

Senator MIKULSKI. Please don't misunderstand. Let me tell you where I am going. This is not a catch question or so on.

Mrs. CABANISS. OK.

Senator MIKULSKI. I wonder if you have had the opportunity to discuss your very important office with Dr. Sullivan, whom I happen to admire a great deal, to ascertain essentially the three things or the navigational chart that you would like to accomplish, say, in the next year or 18 months. I wonder if you would share that with us.

Mrs. CABANISS. All I can say is he has indicated his support for family planning and for the State-administered family planning program. We have not had any extensive discussions on where beyond that we should go in family planning other than his support for separating abortion from family planning.

Senator MIKULSKI. Thank you.

Mr. Chairman, there are many questions, but I would like to yield then to my other colleagues. We know there are many witnesses.

Thank you very much, Mrs. Cabaniss.

Senator ADAMS. Senator Kassebaum?

Senator KASSEBAUM. Mrs. Cabaniss, in your testimony you talked about adolescent family life projects that showed change, when evaluated. You saw that these projects changed attitudes and values in ways which reduce the likelihood of teens engaging in early sexual activity. Among the changes were improved teen-parent communication about sexual matters and values.

I wonder if you could cite some specific projects, or at least one, to show us how you were able to ascertain that these changes took place.

Mrs. CABANISS. OK. Specifically on the parent-teen communication or on reduced sexual activity?

Senator KASSEBAUM. Well, I am interested in parent-teen communication.

Mrs. CABANISS. OK.

Senator KASSEBAUM. Because I think that is an important communication.

Mrs. CABANISS. There are several projects which have shown success in that area. One, which was operated out of Brigham Young University, showed greatly improved parent-child communication, greater comfort in a parent talking to their child about sensitive topics, and also improved attitudes toward the importance of delaying sexual activity.

Another one was operated by the Search Institute out of Minneapolis; another called Sex Respect, out of Illinois; and another called Teen Aid, which is out of Spokane, WA.

In terms of how they get the data, that is the real tough question when you're dealing with an AFL project: How do you get good data on whether teens are sexually active or not, on whether

parent-child communication goes on, what their values are, on even whether they become pregnant or not. It is obviously easy to get data on child births, but not on pregnancies.

The data is normally collected by a pare-test and a post test in which the teenagers coming into the project answers a whole list of questions. At the end of the course she is given another test and the answers are compared, and a number of the questions will be about how often do you talk to your parents, what sort of conversations do you have, what sort of values did your parents communicate?

Senator KASSEBAUM. Are the parents participating as well?

Mrs. CABANISS. Yes. They are required to consent to participation in the program, and a number of the programs in fact are targeted specifically toward patents. In fact, some don't even include adolescents, they are working with parents of preteens to help the parents better educate their children. A number are with parents and teens together.

Senator KASSEBAUM. Are these, on the whole, teens who have been referred by various agencies or school counselors?

Mrs. CABANISS. It normally would be the cross-section of teenagers or preteens that you would find in a public school. Most of our projects are operated in public school systems. Some are operated by youth organizations such as the YWCA, but the majority are operated in public schools.

Senator KASSEBAUM. Thank you.

Senator ADAMS. Senator Coats?

Senator COATS. Secretary Cabaniss, on page four of your testimony you state that the number of low-income women in need of family planning services has decreased over the 8 eight years. Can you elaborate a little bit on this for me, give me some thoughts as to why that might be the case?

Mrs. CABANISS. Well, the judgment or the definition of low-income women in need calculates in women who are sterilized, women who are of reproductive age, and then a low-income calculation. Between 1981 and 1987, the numbers of low-income women in need have actually decreased about 16 percent, from about 9.5 million women to 7.9 million women. A lot of this is due to the childbearing population growing older and women moving beyond childbearing age and a lot of it is more and more women choosing sterilization as their method of contraception. Once a woman is sterilized, obviously she is not in need of further contraceptive services.

Senator COATS. What numbers or percentages do you have regarding the sterilization option?

Mrs. CABANISS. I believe it's about 30 percent of women who are sexually active have been sterilized.

Senator COATS. And typically at what age range?

Mrs. CABANISS. It would be normally among older women. And by that I mean 30 or older.

Senator HATCH. But you are talking about sexually active women.

Mrs. CABANISS. Right.

Senator HATCH. It's 30 percent.

Mrs. CABANISS. Yes. Sexually active.

Senator HATCH. Sexually active.

Mrs. CABANISS. Right.

Senator COATS. Are the Title X funds currently used by organizations, what is the status of use of Title X funds for school-based clinics?

Mrs. CABANISS. At this point, based on our best available data, no Title X funds are going into school-based clinics.

Senator COATS. Indirectly as well as directly?

Mrs. CABANISS. That's correct. Where they would be, the only manner in which Title X funds would be being used in schools would be for sex Ed courses or something of that sort. But our surveys indicate that no funds are going for the provision of contraceptives in schools or for the provision of prescriptions for contraceptives in schools.

Senator COATS. On the subject of this drug being developed in France think it's RU-486——

Mrs. CABANISS. Right.

Senator COATS. Currently there is no research under way in the United States with the use of Title X funds for this particular contraceptive or abortifacient or whatever the description is?

Mrs. CABANISS. Yes. My understanding is within NIH there is some research going on RU-486 but it is not for use of the drug for abortifacient purposes.

Senator COATS. But there are no Title X funds?

Mrs. CABANISS. There are no Title X funds being used. And of course, section 108 of Title X prohibits funding any program where abortion is a method of family planning. So any drug which is an abortifacient could not be used in Title X. It would be inconsistent with the statute. So even if RU-486 were used in the United States, it could not be used in a Title X project.

Senator COATS. Thank you.

Thank you, Mr. Chairman.

Senator ADAMS. Madam Secretary, I have a question about the testimony that you gave with regard to statistical information, which we use a lot of in this Congress—sometimes for terrible purposes, sometimes not so bad. You were exploring whether or not there was an increase in conversation or information between parents and teens, but it seemed to me that your information database was just simply voluntary questions before to a selected group and then voluntary questions parkway through. Is that correct?

Mrs. CABANISS. Well, more or less, yes. In order to get any sort of data on whether a program is effective, you have got to collect pare-test data and post test data. And so for a sex education or a family life education program, the way it is normally done is the students are surveyed beforehand and then surveyed afterwards, and changes in values, changes in their own statements of behavior or behavioral intent are then measured.

Senator ADAMS. What kind of analysis does your department apply to that once you have that raw data?

Mrs. CABANISS. We don't deal with the raw data. In the AFL program every project is required to do their own evaluation.

Take, for example, the Tacoma Peers project, which is in Spokane—not Spokane, excuse me—in Tacoma.

Senator ADAMS. Spokane?

Mrs. CABANISS. Spokane. Right.

They are providing services to pregnant teens. They will collect data on low birth weights, a variety of——

Senator ADAMS. That kind of data I can understand because that is more empirical data.

Mrs. CABANISS. That's good hard stuff. Yes.

Senator ADAMS. In other words, when you're dealing with births, you're dealing with known pregnancies or with examination during periods of known pregnancy, you have a medical record which gives you a certain amount of information.

But what I am really trying to determine here regards some information released, and I don't know whether it was from your department or from you, that Title X programs provided data demonstrating the relative superiority of the abstinence approach. I am trying to determine whether there is any factual data that indicated that was the case. It seemed to me that you have subjective data given to you by individuals that is collected by the YMCA or YWCA. It would seem to me to be a rather biased study, wouldn't it?

Mrs. CABANISS. Well, the projects are required to hire on an independent evaluator who is affiliated with a university in their State, and then that evaluator comes up and designs a pre-post-test survey; and based on that data, the projects report to us what they are finding.

Some of these projects have come up with very positive findings. Others have not come up with particularly positive findings.

Senator ADAMS. You have had a little bit of everything out of your subjective reports.

Mrs. CABANISS. We've got projects that have done well. And we have projects that have found nothing positive. So we have both. We have got some very good ones, and we have some very mixed ones.

Senator ADAMS. Also, I have one other question, and this is my last one. Your need figure seems to me to ignore the rise in percentage of women below the poverty line, for which this program is developed. Have you factored in the rise in the number of women who are under the poverty line?

Mrs. CABANISS. That includes changes, economic changes. For example, in certain regions, specifically the New England region, they have shown a decline of, I believe it is, 37 percent in numbers of low-income women. So some regions where the economic changes have been great have actually shown a major decline in numbers of low-income women.

If I can go back to your previous question. I think one of the things to keep in mind on whether the abstinence approach works best or not is clearly that is the most effective method of contraception, if you will, for teenagers. And we are dealing not just with decisions about pregnancy but we are dealing with major epidemics of certain sexually transmitted diseases. And for those reasons, efforts to encourage teens to postpone sexual activity become, I believe, all the more important.

Some programs are going to be much better at delivering that message than others are, and I think we want to figure out what it is that makes a successful abstinence program and what it is that makes an unsuccessful one. But clearly, all the data is not in.

Senator ADAMS. I see.

Thank you very much, Madam Secretary. We appreciated your testimony.

Senator ADAMS. The next panel will consist of Dr. Federman, whom I want to introduce in a moment, but also I would like to call forward at this time, at the request of Senator Hatch, who really must go, Suzi Dewing, a former service recipient from Pennsylvania.

I hope, Suzi, that you will not mind being called out of order in this matter.

Doctor, if you would be kind enough to forbear so that Senator Hatch, who must leave, will have a chance to question.

I might state while the witnesses are being seated, it is a great honor for the committee to have Dr. Federman here with us today. Senator Kennedy wanted, in particular, Doctor, to welcome you on behalf of the fact that you are a resident of the State of Massachusetts, but even more important, you chair the National Academy of Sciences '"Risking the Future" panel and, of course, are well known and well thought of and well respected professor from Harvard Medical School in Boston.

So, Doctor, we will be looking forward to hearing your testimony.

But at this time we would like to call on you, Ms. Dewing, and I will grant to Senator Hatch the opportunity to question first. But you please go right ahead with your statement, and if you don't want to read the whole thing, just so state for the chairman and I will place in the record the parts that you do not and you may summarize.

STATEMENTS OF SUZI DEWING, FORMER SERVICE RECIPIENT, PENNSYLVANIA; DR. DANIEL D. FEDERMAN, CHAIRMAN, NATIONAL ACADEMY OF SCIENCES "RISKING THE FUTURE" PANEL, AND PROFESSOR OF MEDICINE, HARVARD MEDICAL SCHOOL, BOSTON, MA

Ms. DEWING. I would first like to say thank you very much for this privilege to come here and share my personal experience, and I hope that you will understand that this is a very personal testimony and I have no qualms about any questions that you will have at the end.

Senator ADAMS. We do appreciate that. And we do understand. And thank you for being here. Please proceed.

Ms. DEWING. At the age of 16 I had my first appointment at a local Planned Parenthood clinic, at my boyfriend's insistence. I had just begun having a sexual relationship with him, and he was the first. He drove me to the initial visit at the office in Binghamton, and I was first required to watch a movie, which was outdated, about dating, drinking, and sex. And then shown a movie about—following the movie, excuse me, following the movie, a counselor gave a short presentation to about 10 or 15 of us in the room on the different types of birth control that were available and a very basic explanation about how they were used.

At this time my boyfriend waited for me across the street, in a bar. He was not required to be present. Following the movie and the presentation, there was no time really to ask questions. There

was no mention of any risks involved with being sexually active or the seriousness of sexually transmitted diseases, and abstinence was never suggested. It was not encouraged, and we were not even questioned about our sexual activity.

It was, however, repeatedly stressed that this was all very confidential and that our parents did not need to know that we were receiving services from this clinic. It was very discouraged to discuss any of this with our parents.

A follow-up exam with the Planned Parenthood personnel was scheduled at another day at a local outpatient clinic hospital where a 5-minute interview containing questions about my medical and family history was given in private by a staff person.

I did not know how to answer some of the questions because I was not aware of my own medical history or my family's medical history. So I just guessed or made up answers as we went through the questions.

It was explained to me that the cost of the prescription would be determined by my ability to pay and not by my parents', and therefore it was based on my allowance.

I was given a physical exam with a short explanation of how to take the prescription pills they were giving me. Nothing was said at the time about the time to take them consistently from month to month. The only explanation given was that I should take every pill in the packet; if I should skip one, then I should remember to take two the next day.

I was very inconsistent with the use of the pill over the next 3 years. If my supply ran out before I bought another month's supply, I just waited until my 6 months' appointment to get more, and I used a foam or another method of contraceptive, which had less effectiveness.

When my boyfriend and I would break up, which we did consistently as a teenagers, going back and forth, I would stop taking my pills because I was not being sexually active with him at the time, with the attitude of not wasting them since I was paying for them out of my allowance.

Eventually I would go back and get another supply of pills. And at that time there was never any question about my inconsistency in taking them, although it must have been obvious to the records that I was not purchasing enough pills to get me through the six months. They never questioned the fact or instructed me on the necessity to keep taking the pills from month to month, to take them all the time. And eventually I did get pregnant. Although at the time I didn't know that was the cause of my flu symptoms, it was my mother who took me to her private physician and he diagnosed the pregnancy and immediately recommended an abortion. And I had that abortion 2 days later.

I left that abortion feeling very alone and empty and confused on how this all had happened. I have suffered from it both physically and emotionally. Immediately after the abortion I became obsessed with replacing the baby, and I got married and became pregnant again within six months, only to miscarry two subsequent pregnancies, each time compounding the guilt and the grief and the remorse that I felt over the abortion.

It has taken me years to deal with the pain and to come to an attitude of understanding that my sexual activity at a young age was wrong, it was not an intelligent choice, that I did not receive proper counseling, and that I should have been encouraged to remain abstinent. To get to my appointments at these Planned Parenthood facilities, I rode with my neighbor and two friends, both of whom were 16, and they were all Planned Parenthood clients. And since then they have all become pregnant and had abortions.

I strongly feel that Planned Parenthood did not give me adequate counseling concerning the risks involved with being sexually active at the age of 16, and they interfered with my relationship with my parents by encouraging me to deceive them and not discuss my sexual activity with them or the fact that I was receiving a prescription drug.

They did not treat me on a personal level with concern about my emotional status or conflicts that I might have been having with being sexually active, and I believe that their failure to provide an appropriate counseling service directed my life to several painful circumstances, including the abortion and the results of that.

And I would be glad to take any questions.

[The prepared statement of Ms. Dewing follows:]

PREPARED STATEMENT OF SUZI DEWING

Before the Committee on Labor and Human Resources

of the United States Senate

On S. 110, the Title X Bill

May 9, 1989

At the age of 16 I had my first appointment at a local Planned Parenthood clinic, at my boyfriend's insistence. He drove me to the initial visit at their office in Binghamton, New York.

I was required to watch an outdated movie on dating, drinking and sex, which was followed by a short introduction to the different types of birth control. My boyfriend waited across the street in a bar because he was 18 years old and he was not required to watch the movie.

Following the movie, a counselor gave a short presentation to 10 or 15 of us at once. There was no mention of the risks involved with being sexually active or the seriousness of sexually transmitted diseases. Abstinence was not even suggested. It was, however, repeatedly stressed that this was all confidential and our parents didn't need to know we were obtaining any services at this clinic.

A follow-up exam with Planned Parenthood personnel was scheduled on another day at the local hospital outpatient clinic after hours. A five-

minute interview containing questions about medical and family history was given privately by a staff person. I didn't know the answers to some of the questions about my own medical history, or my family's medical history, so I just made up answers.

It was explained that the cost of the prescription would be determined by my ability to pay and not by my parents' income.

The physical exam was also brief with a short explanation on how to take the pills. Nothing was said about the need to take them consistently from month to month. They also gave me a foam contraceptive to use until the pills became effective.

I was inconsistent with the use of the pill over the next three years. If my supply ran out before I bought more, I just waited until my next six-month exam to get more, and used foam or other methods in between. When my boyfriend and I broke up I would stop taking the pills so as not to waste them. No one at the clinic questioned this inconsistency or explained that it was important to continue the pill ALL the time for it to be effective.

Eventually I did get pregnant. Although at the time I didn't suspect that was the cause of my "flu" symptoms, my mother took me to her private physician who diagnosed the pregnancy and recommended an abortion. I had the abortion two days later. I have suffered from it both physically and emotionally. I became obsessed with replacing the baby and got married and became pregnant again within six months, only to miscarry two subsequent pregnancies, which compounded the guilt and grief of the loss. It has taken years to deal with the emotional pain.

To get to my appointments at Planned Parenthood I rode with my neighbor

and two friends (both 16), all of whom who were Planned Parenthood clients and have since become pregnant and have abortions.

I strongly feel that Planned Parenthood did not give me adequate counseling concerning the risks involved with being sexually active at the age of 16. They interfered with my relationship with my parents by encouraging me to deceive them. They did not treat me on a personal level with concern about my emotional status or moral conflicts. I believe their failure to provide an appropriate counseling service directed my life to painful circumstances.

Senator ADAMS. Thank you very much, Ms. Dewing.

Senator HATCH. Well, thank you for this courtesy, Mr. Chairman. I appreciate it. And I did want to hear Ms. Dewing's testimony.

You have told us on the committee about your experiences when you were 16 years of age. Now do you have any information that would suggest over the last decade Planned Parenthood has not made changes to address your concerns?

Ms. DEWING. Yes, I do, Senator. I have been involved with counseling in a support group atmosphere with other women who have been through similar circumstances both with Planned Parenthood and referrals for abortion and complications from their abortions.

Just recently, in the last 2 years, we had a 16-year-old girl who, after getting pregnant and giving birth to her first baby, began going to Planned Parenthood services at the same place I was, receiving birth control, only to become pregnant within 6 months. And they counseled her for an abortion.

Following that abortion, she again went back to their clinic for services, continued taking birth control pills, and got pregnant a third time. At this time she considered having the baby and sought some alternatives. But again, Planned Parenthood interfered with her, counseled with her to have an abortion, and she did so at 5 months.

Now she is regretting both her abortion experiences. She wishes she had carried both babies to term or one and maybe not getting pregnant again. And she refuses ever to return to a Planned Parenthood clinic.

I see this with several other young girls that I talk with. They are not receiving adequate counseling. They are not being told about the risks involved with getting pregnant and not using the birth control effectively.

Senator HATCH. Well, in light of the concern about sexually transmitted diseases and AIDS, were the women in your support group who had more than one sexual partner encouraged to encourage their partners to use condoms?

Ms. DEWING. No. It was never even questioned. We were never asked how many partners we had, who we were having sex with. And the risks involved with sexually transmitted diseases were not made important. They were almost ignored.

Condom use was hardly even brought up except in the very initial visit as one of the available contraceptives with a high failure rate.

Senator HATCH. Last year, the Congress overwhelmingly passed legislation which stated that all Federally funded AIDS prevention programs should include information about the harmful effects of promiscuous sexual activities, and of course, the benefits of abstaining from such activities.

This legislation also stated that no funds could be used to promote or encourage homosexual or heterosexual activity.

Do you think that Title X clinics should follow that particular Federal law? Would that be your opinion?

Ms. DEWING. Yes. I very strongly feel they should because it is not just a risk of getting pregnant in a sexually active life style but the risks of spreading diseases is not highly stressed enough.

The people that I talk to, the teenagers that are teenagers today, don't seem to have the understanding of the risks that they are taking. They have the attitude of this can never happen to me. And they are not being encouraged to take proper precautions when they go to a service like Planned Parenthood. They are only being given a choice of different types of birth control and that's it.

I am very concerned because I believe that teenagers are being encouraged to be sexually active instead of discouraged, therefore putting them at a very high risk for sexually transmitted diseases.

Senator HATCH. Well, I want to thank you for answering my questions and for being here today. It is not easy to chat about these subjects, but it is important that we approach these things from different points of view, and yours is apparently a very important point of view here today.

I just want you to know that your time has not been wasted in coming and chatting with us.

Ms. DEWING. Thank you, Senator.

Senator HATCH. Thank you.

Senator ADAMS. Senator Kassebaum?

Senator KASSEBAUM. Yes.

You mentioned that in going to the Planned Parenthood center, you were encouraged—is that what you said—not to discuss this with your mother?

Ms. DEWING. Exactly. I wasn't specifically told don't tell your parents, I was told there is no need to, "We will take care of everything, they really probably wouldn't understand or be compassionate. We understand how difficult parental relationships are, and we don't want to put any stress on yours by having them get upset about this. We'll take care of it."

Senator KASSEBAUM. Well, let me ask you, would you have talked this over with your mother?

Ms. DEWING. I believe so.

Senator KASSEBAUM. If you had not gone to a Planned Parenthood center?

Ms. DEWING. Because within a year she approached me on the subject. She came to me to discuss it with me, and my response was, "It's all being taken care of, Mom, you don't need to say anything," because I was already in a Planned Parenthood clinic, trusting in them.

Senator KASSEBAUM. Well, I wonder what sort of responsibility you had at that point because, obviously, you made some choices. You chose to go the Planned Parenthood center, perhaps—maybe because—of your boyfriend's direction.

Ms. DEWING. My boyfriend played a very big role in that. He more or less insisted that I go to a Planned Parenthood clinic and use birth control. And I think I was under the stress that if I did not continue being sexually active with him and take precautions through Planned Parenthood offering me birth control, he would no longer be my boyfriend. And at the age of 16, that was very important to me to maintain the relationship, and I guess I was too willing to do anything to maintain it. And nobody counseled me differently.

Senator KASSEBAUM. Well that is unfortunate. I think, though, that it's not fair to blame the Planned Parenthood centers. I know

there are those that do offer very thorough counseling and encourage parental involvement. So perhaps this was just one center that didn't, or perhaps there were some mistaken interpretations.

Ms. DEWING. Well, I will have to disagree with you on that because from my own personal experience that I stated earlier in counseling and support groups, a number of the women that come to our support groups went to similar Planned Parenthood clinics across the country and none of them were properly counseled either on these topics. So it was not just me.

And like I said, the girl I was telling you about earlier, she recently, within the last year, was going to a Planned Parenthood clinic and was not being counseled on these topics.

Senator KASSEBAUM. Do you feel if they had told you, when you first went to them, that you should go home and talk to your family, that is what you would have done?

Ms. DEWING. I'm not sure if that's what I would have done, but I suspect that it would have discouraged me. It was very difficult to get the courage to go to a Planned Parenthood clinic at the age of 16. And I think if I had been encouraged to go home and rethink about my sexual activities and discuss them with my parents, I probably would have changed my whole attitude toward having sex.

Senator KASSEBAUM. Thank you, Mr. Chairman.

Senator ADAMS. Ms. Dewing, how old are you now?

Ms. DEWING. I am 31.

Senator ADAMS. What is the name of the groups that you work with now?

Ms. DEWING. Pardon me?

Senator ADAMS. What are the names of the groups that you work with now?

Ms. DEWING. I don't work directly with any groups right now. Our counseling service is not really a public counseling service in the sense that we are incorporated or anything like that. We are just a group of women who have had similar conflicts with our sexuality and abortion experiences and we meet on a monthly basis as a support group.

Senator ADAMS. Where do you live? Where did this happen?

Ms. DEWING. Pardon me?

Senator ADAMS. Where did this Planned Parenthood experience occur?

Ms. DEWING. This was in Binghamton, NY.

Senator ADAMS. In?

Ms. DEWING. Binghamton, NY.

Senator ADAMS. Binghamton, NY. Are you still there?

Ms. DEWING. No, I am only 20 miles south of the border into Pennsylvania. It is still a very—it's the closest major city to where I live.

Senator ADAMS. I want to echo what Senator Kassebaum said, that your experience as you described it is certainly not the type of experience that I have had reported to me from other Planned Parenthood groups in the areas from which I come. There is a great deal of effort made to have the young women speak with their parents in a discussion if they wish to do so. So your experience does not, as I say, match what I have heard reported before. I do not

deny that something like this might have happened. That is why I asked where you were from and how old you are now because I know very few clinics where that might occur.

Senator Coats?

Senator COATS. Just to follow up on some earlier questions.

Did you say you are active with a nationwide group that counsels young women?

Ms. DEWING. I have been active within a nationwide group that counsels young women called Open Arms, but I am no longer representing them.

Senator COATS. How recently were you active with them?

Ms. DEWING. I resided my position a year ago in January.

Senator COATS. And the information that you have received back from this group is that experiences similar to yours are commonplace?

Ms. DEWING. Yes.

Senator COATS. In Planned Parenthood?

Ms. DEWING. Yes, that's true but not——

Senator COATS. Clinics across the county?

Ms. DEWING. But not just in that national group, but also in our local support group which I am still active with.

Senator COATS. But that would relate just to one specific Planned Parenthood

Ms. DEWING. Right, but the national organization which Open Arms is for a support group for women who have had abortions and had complications with their sexual activities, I would not say 100 percent but probably a very large percentage of women have had similar types of conflicts with Planned Parenthood and their counseling.

Senator COATS. How extensive was that group that you were part of, Open Arms?

Ms. DEWING. National organization.

Senator COATS. How many chapters, do you know?

Ms. DEWING. I don't know the exact number of chapters today.

Senator COATS. Let me just ask you a separate question, and I am not asking you for a statistical analysis or anything. But in your opinion, are attitudes changing among teenage girls in particular toward sexual activity, toward concern about sexually transmitted diseases, or are they the same as they were when you were 16? Is it worse, is it getting better? Are attitudes changing? Do you notice any difference?

Ms. DEWING. Like I said earlier, the attitude that I notice more than any of the others is the attitude of this cannot really happen to me in my little life with my few little friends and associates within school district; AIDS and other sexually transmitted diseases, well, it's not going to happen to me or I am the one that's not going to get pregnant.

I don't think they have really changed an awful lot, from my experience with teens.

Senator COATS. What is the best way, in your opinion, to spread that information and to effect those attitudes or get people to start thinking about that?

Ms. DEWING. Well, I certainly hope I have been able to by going into the schools and the health classes and sharing my personal ex-

perience to enlighten them to what they may be taking a risk at. And I also would like to see more encouragement toward abstinence within the community and certainly a lot more family involvement with these decisions.

Senator COATS. Do you think encouragement toward abstinence will make a difference?

Ms. DEWING. Oh, I certainly believe that.

Senator COATS. Does it affect a 16-year-old?

Ms. DEWING. I certainly believe that the 16-year-old wants to be told that, "You don't have to be sexually active. It's not necessary now. You should wait. It is for your own health and reproductive freedom to wait."

Senator COATS. But don't most of them take the attitude that you expressed earlier that, well, maybe that's true but it's not going to affect me, it's not going to happen to me.

Ms. DEWING. I do believe that that—you know, those that are sexually active now have that opinion, but I also believe those that are on the line of decision making would like to decide not to be sexually active and take the risk.

Senator COATS. Is there a lot of peer pressure to be sexually active?

Ms. DEWING. I don't know.

Senator COATS. Thank you very much for your testimony.

Thank you, Mr. Chairman.

Senator ADAMS. Thank you, Senator Coats.

Thank you, Ms. Dewing.

It gives me a great deal of pleasure now to welcome our second panel, Dr. Daniel Federman from the Harvard Medical School.

Dr. Federman, we would be pleased to receive your testimony.

Dr. FEDERMAN. Mr. Chairman and members of the committee, I am Dan Federman, professor of medicine at Harvard Medical School.

I am reporting to you as chairman of a panel appointed by the National Academy of Sciences' National Research Council. Our charge was to review and evaluate the scientific information available on adolescent sexuality, pregnancy, and childbearing. We were asked to prepare a research evaluation, not a set of policies or recommendations expressing the beliefs of any one group.

In view of this background, you may be surprised to find me beginning with a clinical rather than a quantitative statement. But there is no question that the dominant impression one gains from involvement in this field is the tragic toll of human loss, wasted opportunities, wasted personal potential, and wasted social contribution.

There are one million pregnancies to women and girls under age 20 in our country. As we have heard, these result in at least a half a million live births and over 400,000 abortions. By far, the majority of births are to single women whose potential for personal achievement and social contribution is blunted by the demands of child care at a time when they could be learning and preparing for adulthood.

Adolescent sexual activity in the United States is no greater than in 30 other Western countries with which scientific comparisons are available. But our rates of pregnancy, abortion, and child-

bearing are greater than for any other Western country and more than twice as high as some. This combination of similar rates of sexuality but much higher rates of pregnancy and childbearing is primarily due to the lack of broadly available, effective, and regularly used family planning and contraception.

No ethnic, religious, social, or economic group is free of the problem of unintended teenage pregnancy, but the rates of sexuality and pregnancy are highest in association with poverty, and thus blacks and Hispanics are disproportionately affected.

An image is almost more compelling than statistics. The most commonly affected girl or woman is a teenagers from a poor, single-parent family. She is doing poorly in school and sees little hope for her future, with limited models of family, school, or occupational attainment.

It is quite likely she was herself the child of a teen parent and that the constriction of opportunities resulting from that is now a mantle laid on her child and her child's

The consequences of teenage pregnancy are similarly well known. The pregnancies are disproportionately complicated for both mother and child. Low birth weight and increased frequency of infantile and childhood illness, poor school performance, and later, poor economic achievement all await the child of the teen mother. For girls, there is an increased likelihood of being a teen mother a short 12 to 16 years later. During much of this time, dependency on welfare support is common.

The panel's research demonstrated beyond doubt that the one intervention clearly capable of reducing the toll of teenage pregnancy and childbearing is effective contraceptive services.

Several powerful social and economic consequences of this can be recognized. First, the costs of preventive services is so small relative to the costs of premature pregnancy that a program does not have to be very effective to be cost effective. The reduction in unwanted pregnancies will quickly return the cost of preventive interventions many times over.

Further, it is not unimportant to point out that prevention of pregnancy eliminates the consideration of abortion.

The panel's recommendation for the renewal of Title X is directly transferable to support for S. 110. In making family planning services available to teens regardless of ability to pay, the Government is supporting the one proven intervention and, in addition, is choosing a highly cost-effective approach.

In supporting research on pregnancy prevention, this bill should also lead to better ways to influence teen behavior, specifically to delay sexual activity.

The programs supported by S. 120 would complement those of Title I. Care grants would provide pregnancy-related services for teens. Effective prenatal care reduces the complications of pregnancy as well as the medical and social complications for the resulting child. Pathology previously attributed to the reproductive immaturity of the mother is almost eliminated by effective prenatal care. The support of such care by this proposed legislation would thus bring benefits to both mother and child, and the costs would be returned many times over by the resulting savings.

S. 120 also proposes prevention grants in which new efforts to achieve delay in sexual debut and consequent pregnancy would be studied. Where such efforts succeed, everyone benefits. Where they fail, referral to family planning services will provide needed support for the teen.

Finally, S. 120 requires evaluation of programs and further research into potential effectiveness. Our panel deplored the lack of clear evaluation of many prior efforts and urge that in the future both preventive and care services be evaluated so that more effective spending of public and private dollars will ultimately be achieved.

I would like to close by quoting a short paragraph from our preface:

> No human experience is at once so transiently private and lastingly public as an unintended pregnancy. When the mother is herself a young adolescent only partially educated and almost wholly economically dependent, the pregnancy is inevitably enmeshed in a ragged tapestry of personal, interpersonal, social, religious, ethical and economic dimensions. Many social circumstances are closely related to the problem of teenage pregnancy and childbearing. Youth unemployment, poverty, poor education, single-parent families, television content, all these and more are accompaniments and likely determinants of the high rates in the United States. The hope for a solution to the problem of teenage pregnancy is illusory without amelioration of some of these contributing factors. Pending such comprehensive change, however, the panel urges prevention rather than denial, kindness rather than exhortation, and research rather than doctrine.

Thank you for the chance to testify. I would be glad to answer questions.

[The prepared statement of Dr. Federman follows:]

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PREPARED STATEMENT OF DR. DANIEL D. FEDERMAN

May 9, 1989

Mr. Chairman and Members of the Subcommittee, I am Daniel Federman, Professor of Medicine at Harvard Medical School. I am reporting to you as Chairman of a panel appointed by the National Academy of Sciences National Research Council. Our charge was to review and evaluate the scientific information available on adolescent sexuality, pregnancy, and childbearing. Our panel was probably unique in two respects - one was the breadth of scientific, scholarly, and public health background of its members and its charge. The second is that we were asked to prepare a research evaluation, not a set of policies or recommendations expressing the beliefs of any one group.

I. The research results

A. Introduction

In view of this background, you may be surprised to find me beginning with a clinical rather than a quantitative statement. But there is no question that the dominant impression one gains from immersion in this field is the tragic toll of human loss - wasted opportunities, wasted personal potential, and wasted social contributions.

Second, let me give you a numerical summary. There are one million pregancies per year to women and girls under age 18 in our country. From the reports of the women themselves, at least 80% of these are unintended. These pregnancies occasion over 400,000 abortions and more than 500,000 births. By far the majority of births are to single women whose potential for personal achievement and social contribution is blunted by the demands of childcare at a time when they should be learning and preparing for adulthood.

Perhaps a better way to convey the circumstances is to indicate that every two minutes a baby is born to a young teen who is barely adolescent, let alone adult herself.

B. The facts

Adolescent sexual activity in the United States is no greater than in over 30 other Western countries with which scientific comparisons are available. But

our rates of pregnancy, abortion, and childbearing are greater than for any other Western country and more than twice as high as some.

This combination of similar rates of sexuality but much higher rates of pregnancy and its complications indicates that the principal difference in the United States is the lack of broadly available, effective, and regularly used contraceptive techniques. Since much of teenage pregnancy is inextricably linked with poverty, teenage unemployment, and single parent families, public funding of services to teenagers is critical.

II. Antecedents and consequences of teenage pregnancy

A. Antecedents.

No ethnic, religious, social, or economic group is free of the problem of unintended teenage pregnancy. But the rates of sexuality and pregnancy are highest in association with poverty and thus Blacks and Hispanics are disproportionately affected. An image is almost more compelling than statistics: the most commonly affected girl or woman is a teenager from a poor, single parent family. She is doing poorly in school and sees little hope for her future, with limited models of family, school, or occupational attainment. It is quite likely she was herself the child of a teen parent, and that the constriction of opportunities resulting from that is now a mantle laid on the new teen's (and her child's) child. Many other factors can be identified. These include high rates of male unemployment, drug abuse in the environment (not specifically in the woman), ignorance about sexuality, sexually stimulating television content and rock music, etc. But the image is not all negative by any means. For some young women, the prospect of a baby to love and care for is a distinctly positive, beckoning motivation.

B. Consequences

The consequences of teenage pregnancy are similarly well known - and sad. The presence of the pregnancy tends to be recognized late, partly because teenagers'

menses are often irregular and partly because reproductive services are not readily available. The pregnancies are disproportionately complicated, with negative consequences for both mother and child. Low birth weight, an increased frequency of infantile and childhood illness, poor school performance, and later poor economic achievement all await the child of the teen mother. For girls, there is an increased likelihood of being a teen mother a short 12 to 16 years later. During much of this time, dependency on welfare support is common.

III. Research conclusions regarding programs.

The Panel's research demonstrated without doubt that the one intervention clearly capable of reducing the toll of teenage pregnancy and childbearing is effective contraceptive services. Several powerful social and economic consequences of this must be recognized. First, the cost of preventive services is so small relative to the cost of premature pregnancy that a program does not have to be very effective to be cost-effective. The reduction in unwanted pregnancies will quickly return the cost of preventive interventions many times over. Second, one is not truly striving for pregnancy elimination but for delay. Our Panel's report includes an economic analysis showing the enormous financial benefit of just delaying all teenage pregnancies by one year. Further, it is not unimportant to point out that prevention of pregnancy eliminates the consideration of abortion.

The Panel's recommendation for the renewal of Title X is directly transferable to support for S.110. In making Family Planning Services available to teens regardless of ability to pay, the government is supporting the one proven intervention. In addition, it is choosing a highly cost-effective approach.

In supporting research on pregnancy prevention, this Bill would contribute to correcting a tragic deficiency of modern American medical science. At a time when reproductive biology and related sciences are unprecedentedly strong and promising, research on contraception in the United States has almost halted, and the public availability of effective contraception has been progressively constricted. It is of course true that a significant cause of this lack of research is a concern about product liability. But government support and encouragement of research would be helpful in two ways. It would certainly lead to the development of new contraceptives.

But we need research into better ways to influence teen behavior, specifically, to delay sexual activity.

The programs supported by S120 would complement those of Title X. Care grants would provide pregnancy related services for teens. Our Panel's research clearly documents that effective prenatal care reduces the complications of pregnancy as well as the medical and social complications for the resulting child. Pathology previously attributed to the reproductive immaturity of the mother has in fact been shown to be almost eliminated by effective prenatal care. The support of such care by this proposed legislation would bring those benefits to both mother and child; and the costs would be returned many times over by the resulting savings.

S120 proposes prevention grants, in which new efforts to achieve delay in sexual debut and consequent pregnancy would be studied. Where such efforts succeed, everyone benefits. Where they fail, referral to family planning services, and the provision of family planning services where they are not available, will provide complementary support for the teen.

Finally, S120 requires evaluation of programs and further research into potential effectiveness. Our Panel lamented the lack of clear evaluation of many prior efforts. We urge that in the future, both preventive and care services be evaluated so that more effective spending of public and private dollars will ultimately be achieved.

Senator ADAMS. Thank you very much, Dr. Federman.

Dr. Federman, I am concerned about some of the statements that have been made today and are made generally about the "Just say no." I think it happens to work better in some groups than others. And I wanted to ask you this:

Is there, in your judgment, Dr. Federman, any scientific justification for continuing to require adolescent pregnancy prevention programs funded by Title XX to focus primarily on abstinence?

Dr. FEDERMAN. In the research that we reviewed, there was a lot of attention to programs that encouraged abstinence, and there was not any convincing evidence that approach reduced pregnancy rates. There are certainly individual experiences that can be cited where that helps, but it would be no way that the research would justify abstinence or delay as the primary focus of Title X.

Senator ADAMS. I have a second question, Dr. Federman. I understand that the "Risking the Future" adolescent pregnancy literature review that came out in 1987 has been updated in an article by Jean Brooks-Dunn, which is being considered for publication by the American Psychological Journal.

Have you discussed Dr. Brooks-Dunn's findings with her, and has there been any research conducted in the last 2 years that would change your personal scientific opinion about the National Academy's recommendations which you have just given to this committee?

Dr. FEDERMAN. I have not discussed the paper with Dr. Brooks-Dunn. I have read it. It is specifically described as an updating of her view since "Risking the Future," the NAS panel report. And it confirms in considerable detail the conclusions we reached and the recommendations we made. It does not lead to any change, and the recommendations of our panel, and it does bring them up to date.

Senator ADAMS. Thank you very much, Dr. Federman.

The Chair will announce at this time that the record will remain open for 5 days for additional questions because several members have asked me if they might submit some questions in writing, and I would ask the witnesses, if that is acceptable to them, to answer questions in writing if submitted by the committee within the next 5 days.

All right. It is so ordered.

Senator KASSEBAUM. Mr. Chairman, may I ask, does that mean that we will not be marking up this legislation in the committee on Friday, as had been announced?

Senator ADAMS. Oh, you are correct. Then we will be submitting questions in writing, but it will be done immediately, and the questions should be submitted by Thursday.

Senator KASSEBAUM. And then we will mark up on Friday?

Senator ADAMS. On Friday.

Senator KASSEBAUM. Oh. I thought you said 5 days.

Senator ADAMS. I did. That was a mistake. I will correct it. That order will be vitiated, and we will issue them on Thursday. I appreciate very much your reminding me of the calendar, Senator.

Senator KASSEBAUM. Thank you, Mr. Chairman.

Dr. Federman, in your testimony, you say that the panel found that the one intervention that is clearly capable of reducing teenage pregnancy is effective contraceptive service.

Did you look at interventions such as parental involvement, or efforts to convince teenagers to delay sexual activity? Did you find any way to measure these interventions?

Dr. FEDERMAN. We looked at it extensively. We had both a review of published literature, consultation with many people in the field, and testimony from providers in the field. So we made our best effort to look at what was written but also to talk to people who have been working in this area.

In objective terms, it was very hard to find evidence that efforts at delay or efforts at discouraging sexual activity were effective. As I mentioned earlier, the standards of research in the field are not strong, and there has seldom been really good funding for research to accompany provision of services. One of our hopes would be that legislation would correct that.

But within the published literature, there is almost no cause for optimism on that side.

Senator KASSEBAUM. I am very appreciative of your explaining the lack of real research, and particularly the lack of evaluation of programs. I think we have not done a very good job in this area. We now have a number of years' experience, so we could go back and make some evaluations. That, it seems to me, could be very valuable as we address current needs and those of the future. I think that the absence of information is a very important point that you made in your testimony.

Thank you, Mr. Chairman.

Senator ADAMS. Thank you, Senator Kassebaum.

I want to thank you, Dr. Federman, for being on the panel and for your testimony. We will submit the questions prior to Thursday if there are any written questions. And we will look forward to marking up on Friday.

At this time the Chair would call for panel III: Mr. Thomas Kring, president, the National Family Planning and Reproductive Health Association, from Los Angeles, CA; Faye Wattleton, president, Planned Parenthood Federation of America, New York, NY.

We have heard from Suzi Dewing. If she wishes to remain in the panel, she may do so. Otherwise, we will prepare to hear from panel III.

Is there any preference between our two witnesses as to which one shall proceed?

[No response.]

Senator ADAMS. All right. Then, Dr. Kring, if you wish to start, we, as the Chair has stated before, would be pleased to hear your testimony in full. If you wish to summarize, the Chair would also be pleased to place your statement in the record in full.

STATEMENT OF THOMAS C. KRING, PRESIDENT, NATIONAL FAMILY PLANNING AND REPRORUCTIVE HEALTH ASSOCIATION, LOS ANGELES, CA, ACCOMPANIED BY FAYE WATTLETON, PRESIDENT, PLANNED PARENTHOOD FEDERATION OF AMERICA, NEW YORK, NY

Senator ADAMS. All right. Then, Dr. Kring, if you wish to start, we, as the Chair has stated before, would be pleased to hear your

testimony in full. If you wish to summarize, the Chair would also be pleased to place your statement in the record in full.

Mr. KRING. Mr. Chairman, members of the committee, I will summarize and attempt to stay within the time frame.

Senator ADAMS. Your full statement will appear in the record as given, Mr. Kring.

Mr. KRING. I am Thomas Kring. I am an ordained Methodist minister and executive director of the Los Angeles Regional Family Planning Council, the California Family Planning Council, and I am here today representing both of these family planning councils as well as the National Family Planning and Reproductive Health Association, of which I am the elected president.

I thank you for this opportunity to testify in support of the reauthorization of the National Family Planning Program, Title X of the Public Health Service Act.

In particular, NFPRHA and the family planning community as a whole strongly endorse the passage of S. 110, the Family Planning Amendments of 1989.

The family planning program in California will receive approximately $12 million in Title X funds for the provision of family planning in this year and for other related primary care to low-income clients. The California Family Planning Council, along with the Los Angeles Regional Family Planning Council, allocates these funds to 82 agencies which together have 228 clinic sites located throughout the State. The clinics funded by these two organizations, LARFPC and CFPC, provide comprehensive family planning services to over 450,000 low-income women per year. Over 85 percent of those are below 100 percent of poverty.

The National Family Planning and Reproductive Health Association is the only national organization representing the entire family planning community. NFPRHA represents 74 of the 89 Title X grantees across the United States who in fiscal year 1989 received nearly 90 percent of the Title X family planning service dollars. Among those NFPRHA represents are hospitals, State and local health departments, affiliates of the Planned Parenthood Federation of America, independent nonprofit family planning agencies, nonprofit family planning councils, individual doctors, nurses, researchers, and consumers of reproductive health care services.

Title X is primarily a health service that serves the poor and the medically indigent. Through a network of approximately 4,000 clinics throughout the country, family planning agencies serve as the entry point for millions of low-income women and adolescents into the Nation's health care system. As most clients do not have access to health insurance or to any other Government-subsidized health care such as Medicaid, services are available in most places at no cost or on a sliding-fee schedule based on the client's ability to pay.

Thus, for many these clinics are the only source of health care readily available and, in many cases, the only source, period, of health care available to them.

Title X-funded family planning clinics provide a variety of health care services and information for men and women. These services comprise a much broader than people realize. They include education on reproductive health, on all medically acceptable methods of birth control, including natural family planning. They provide con-

traceptive supplies with appropriate instructions, complete health screening assessments, laboratory tests to screen for sexually transmitted diseases, cervical and breast cancer, anemia, hypertension, pregnancy testing and referral, adolescent health education, community health education.

Some family planning clinics also provide the additional services of prenatal care, infertility diagnosis and treatment, sterilization, male programs, and HIV testing.

Counseling is available for all patients, as is instruction pertaining to self-breast exam, human sexuality, and nutrition. Referrals are made for additional services as necessary. Use of our clinics is extremely and totally voluntary and confidential.

While the major purpose of Title X is to increase access to contraceptive services in an attempt to reduce unintended pregnancy, it serves a variety of personal as well as social purposes, among them upgrading of general reproductive health, the prevention or alleviation of poverty and improving the health and economic well-being of individual women and their children and their families.

Since Title X services are not limited to the poorest of the poor nor to women on welfare, Title X also plays an important part in helping marginal-income families remain independent financially.

The need for the Title X is clear and considerable. Unfortunately, due to budget cuts and the priorities established by previous Administrations for this program, data for the family planning program has not been collected or compiled since 1983.

Many questions have been asked about data today, and I point out that the contract for data was canceled in 1983 by the Office of Population Affairs, and no data has been compiled effectively about the family planning program, even to the point that we don't know for sure how many clinics exist in the country today.

However, according to the latest data available—and this is 1983 data—3.5 million low-income women and 1.5 million teenagers receive Title X-funded services annually. I want to stress there that is two-thirds of the clients or adults, one-third of teens. And when we talk about teens, we are talking about those under age 19. Two-thirds of those are between the age of 18 and 19. So the number of adolescents actually served in the Title X program is considerably smaller than what is often implied.

The average client in 1983 was a young female with lower marginal income; 69 percent of the clients were white, with 80 percent having incomes below 150 percent of poverty. Current data from California validates these figures except to show that our poverty level has increased considerably.

In spite of these numbers, 56 percent of the over 9.5 million low-income women and 65 percent of the 5 million sexually active teens in need of subsidized family planning services still cannot obtain such services.

The effectiveness of our services has been well established. Studies show that during the first decade of the Title X program, 5.4 million pregnancies were averted, 2.3 million abortions were averted, 2.5 million miscarriages averted. The Federal family planning program has served a total of 32.3 million patients in patient years during this time. Clearly, in socioeconomic terms, Title X is cost effective.

We have heard testimony about teenagers, and I will omit that part and talk about primarily the Federal dollars invested in Title X to prevent pregnancy more than pay for themselves in savings in public health care and social service costs. This has been well documented.

A recent study done by the University of California in San Francisco at the medical school documented that for every $1 spent in family planning services in California, the State saved $11.50 in later costs.

Unfortunately, Federal, State, and local financial support for family planning has never reached the level commensurate with the need. Since the early 1970's the number of medically indigent family planning clients has grown more than 60 percent. And yet, Federal funding for family planning has decreased in real dollars since 1973.

Congressional passage of S. 110 will go a long way to ensuring that low-income women and sexually active teens will not have to go without high-quality, comprehensive family planning and reproductive health care services they so desperately desire and need to prevent unintended pregnancies and the severe consequences associated with such pregnancies.

The authorization of the Title X statute expired in 1985. For the last four fiscal years the Title X appropriation has been carried on a series of continuing resolutions. The result has been a reduction in funds appropriated for Title X and an inability of the program to institute needed statutory reforms.

In the last 8 years, the appropriation for Title X has gone from $162 million in fiscal year 1981 to $135 million in 1989. Inflationary increases alone, figured conservatively at 4 percent per year, would have brought the current level of Title X funding to in excess of $230 million for this year.

According to the HHS figures, the funding reductions directly attributable to the lack of reauthorized Title X statute forced the closing of approximately a thousand family planning clinics and the curtailment of many services. Operating hours in our clinics have been reduced, staffs have been cut, indigent patients have been asked to contribute more to the cost of services, and in some cases the waiting time is today more than 2 months.

The irony of this, of course, is the reducing a program as effective and cost efficient as Title X results in far greater social and financial costs down the line.

By providing modest increases in authorized funding levels for basic family planning services, training programs and technical assistance programs, S. 110 will permit the restoration of some of the services and the provision of preventive reproductive health services to additional clientele.

S. 110 proposes some modifications to the program which the next witness will be speaking about. The National Family Planning Program strongly supports these initiatives and strongly supports S. 110. We wholeheartedly endorse the passage of S. 110 and the reauthorization of the Title X family planning statute for 3 years.

Mr. Chairman, members of the committee, I thank you for the opportunity to present this testimony, and I will be pleased to answer any questions.

[The prepared statement of Mr. Kring follows:]

PREPARED STATEMENT OF THOMAS C. KRING

Mr. Chairman and Members of the Committee:

I am Thomas C. Kring, Executive Director of the Los Angeles Regional Family Planning Council, Inc. (LARFPC), and the California Family Planning Council (CFPC). I am here today representing the two California family planning agencies as well as the National Family Plannning and Reproductive Health Association (NFPRHA), of which I am the elected President. I thank you for this opportunity to testify in support of the reauthorization of the national family planning program -- Title X of the Public Health Service Act. In particular, NFPRHA and the family planning community strongly endorse the passage of S. 110, the "Family Planning Amendments of 1989."

The family planning program in California will receive approximately $12 million in federal (Title X) funds for the provision of family planning and other related primary health care services to low-income clients in 1989. With only a few exceptions, all of the clinics in California funded with federal dollars also receive funding from the State Office of Family Planning.

The Los Angeles Regional Family Planning Council, Inc. receives and subsequently allocates these public monies to 33 agencies which together have

83 clinic sites located throughout Los Angeles County. The California Family Planning Council allocates family planning funds to 49 agencies which together have 145 clinic sites located throughout the State of California, excluding Los Angeles County. The clinics funded by these two organizations, LARFPC and CFPC, provide comprehensive family planning services to over 450,000 low-income clients each year.

The National Family Planning and Reproductive Health Association (NFPRHA) is a non-profit membership organization headquartered in Washington, D.C., established to improve and expand the delivery of voluntary family planning and reproductive health services throughout the United States. As the only national organization representing the entire family planning community, NFPRHA's members comprise almost all grantees funded under the national Title X family planning program.

NFPRHA represents 74 of the 89 Title X grantees across the United States who, in fiscal year 1989, received nearly 90 percent of the Title X family planning service dollars. Among those NFPRHA represents are hospitals; state and local health departments; affiliates of the Planned Parenthood Federation of America; independent non-profit family planning agencies; non-profit family planning councils; individual doctors, nurses, and researchers; and consumers of reproductive health care services. NFPRHA is committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

Title X -- A NECESSARY PUBLIC HEALTH PROGRAM

In a message to the Congress in July 1970, President Richard M. Nixon stated,

> "It is my view that no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do."

The Family Planning Services and Population Research Act (P.L. 91-572) subsequently was signed into law by President Nixon in December 1970. The national family planning program has since become an integral component of the myriad of programs designed to improve public health in the United States.

This significant commitment to public funding for family planning services was an outgrowth of several events in the 1960s. The emergence of the oral contraceptive (the "birth control pill") and the intra-uterine device (IUD) made relatively safe, effective and convenient contraception a reality for American couples. Research studies documented that repeated, closely spaced childbearing and childbearing very early or very late in a woman's reproductive years often had adverse health, social and economic consequences both for mothers and for their children. Other studies showed that most low-income women and men in the United States did not want more children than did more affluent families; rather, since they lacked the same level of access to contraceptive services, they were less successful in having the smaller families they desired. And finally, the U.S. Supreme Court recognized in 1965 (GRISWOLD) the right of couples to practice contraception, and in 1982 (BAIRD) extended that right to single individuals as well.

Title X is primarily a health services program that serves the poor and medically indigent. Through a network of over 4,000 clinics, family planning agencies serve as the entry point for millions of low-income women and adolescents into the nation's health care system. As most clients do not have access to health insurance or to any other government subsidized health care (i.e., Medicaid) services, services are available at no cost or on a sliding fee scale based on a client's ability to pay. Thus, for many, these clinics are the only source of health care readily available.

Title X-funded family planning clinics provide a variety of health care services and information for men and women. These services comprise a much broader range than most people realize, including education on reproductive health systems and all of the medically acceptable methods of birth control, including natural family planning; contraceptive supplies with appropriate instructions; a complete health screening assessment; laboratory tests that screen for sexually transmitted diseases, cervical and breast cancer, anemia, and hypertension; pregnancy testing and referral; adolescent health education and community health education. Some family planning clinics also provide the additional services of prenatal care, infertility diagnosis and treatment, sterilization and male programs. Counseling is available for all patients, as is instruction pertaining to breast self-examination, human sexuality and nutrition. Referrals are made for additional services as necessary. Use of all clinic services is entirely voluntary and confidential.

While the major purpose of Title X is to increase access to contraceptive services in an effort to reduce unintended pregnancy, it serves a variety of

personal as well as social purposes, among them the upgrading of general reproductive health, the prevention or alleviation of poverty and improving the health and economic well-being of individual women, their children, and their families. Since Title X services are not limited to the poorest of the poor, nor to women on welfare, Title X also plays an important role in helping marginal-income individuals and families remain independent financially.

The Title X network is incredibly diverse, with various types of providers offering family planning services with Title X funds. State and local health departments constitute the single largest group of providers, serving 40 percent of the Title X clients. Affiliates of the Planned Parenthood Federation of America serves 27 percent of the clients; hospitals, 13 percent; and a variety of other agencies such as health maintenance organizations, community health centers, and independent clinics serve the remaining 20 percent.

This network, established and operated under the Title X program, provides the infrastructure for the organized delivery of publicly-funded family planning services. While Title X is a major source of public support and the only program dedicated to family planning -- providing nearly one-third of the total public family planning funds -- it is augmented by: the Maternal and Child Health Block Grant (Title V of the Social Security Act); Medicaid (Title XIX of the Social Security Act); the Social Services Block Grant (Title XX of the Social Security Act); state and local funding; patient fees; other third party reimbursements; and private philanthropy.

The need for the Title X program is clear and considerable. Unfortunately, due to budget cuts and the priorities established by the Administration for this program, data for the family planning program has not been adequately collected or compiled since 1983. However, according to the latest data available, 3.5 million low-income women and 1.5 million adolescents receive Title X funded services annually. The average client in 1983 was a young female with a low or marginal income. Sixty-nine percent of the clients were white with eighty percent having incomes below 150% of the federal poverty level. Current data from California validates these figures except that the number of women below the poverty level has increased considerably. In spite of these numbers, 56 percent of the over 9.5 million low-income women and 69 percent of the five million sexually-active teenagers in need of subsidized family planning services still cannot obtain such services.

The effectiveness of family planning services has been well established. Studies show that during the first decade of the Title X program 5.4 million pregnancies were averted, 2.3 million abortions were averted, and 2.5 million miscarriages were averted. The federal family planning program served 32.3 million patients (in patient years) during this time. Clearly, in socio-economic terms, Title X is cost-effective.

Former Department of Health and Human Services Secretary Otis R. Bowen has noted, "Between their 13th and 19th birthdays, more than one quarter of all teenage girls will be pregnant at least once. Pregnancy among unmarried teens is a problem for both the girls having babies and the boys who father them.

And it is a problem we all must face . . . not just the government, but all of us."

The problem is not simply whether a pregnant teenager chooses to give birth or to have an abortion. The Center for Population Options documented in its 1986 study of the public costs of teenage childbearing,

> The more than one million teenage pregnancies that occur each year are a serious problem for all of society. Not only is teenage childbearing a threat to the health and welfare of the mother and child, but adolescent pregnancy contributes to such a societal problem as poverty, unemployment, family disintegration, juvenile crime, school dropouts and child abuse.

More often than not, teenagers who become pregnant have few marketable skills, too little education and few resources for adequate support. This study further states that the United States government spent $18 billion in 1986 for families that were begun when the mother was a teenager. This figure is conservative because, while it includes direct and administrative costs for Aid to Families with Dependent Children, food stamps and Medicaid, it does not take into account associated costs such as social services, public housing and child care. The report also estimated that babies born to teenagers in 1986 alone would cost the U.S. $5.5 billion over the next twenty years.

Additionally, the National Academy of Sciences' Institute of Medicine reported in 1985 on the twin problems of low birthweight and high infant mortality in the U.S. relative to other industrialized nations. The study specifically found that access by low-income women and unmarried teenagers to Title X

family planning services can significantly reduce the incidence of low birth weight babies and high infant mortality.

Thus, the federal dollars invested in Title X to prevent pregnancy more than pay for themselves in savings in public health care and social services costs. In fact, a recent study done by the University of California in San Francisco documented that for every $1.00 on family planning services in California, the State saved $11.50 in later costs.

Unfortunately, despite the Presidential call for total access to family planning services by 1975, federal, state, and local financial support for family planning has never reached a level commensurate with need. Since the early 1970's, the number of medically indigent family planning clients has grown more than 60 percent, yet federal funding for family planning has decreased in real dollars since 1973.

Congressional passage of S. 110 will go a long way to ensuring that low-income women and sexually active teenagers will not have to go without the high-quality, comprehensive family planning and reproductive health care services they so desperately desire and need to prevent unintended pregnancies and the severe consequences associated with such pregnancies.

S. 110 -- A STEP FORWARD

The authorization of the Title X statute expired on September 30, 1985. For the last four fiscal years, the Title X appropriation has been carried on a

series of Continuing Resolutions and the FY 1989 DHHS appropriations act. The result has been a reduction in the funds appropriated for Title X and an inability of the program to institute needed statutory reforms.

In the last eight years, Title X's appropriation has gone from $162 million in FY 1981 to $135.1 million in FY 1989. Inflationary increases alone (figured conservatively at 4% per year) should have brought the current level of Title X funding to an excess of $230 million by this year.

According to DHHS figures, the funding reductions directly attributable to the lack of a reauthorized Title X statute forced the closing of almost 1,000 family planning clinics and the curtailment of many services. Operating hours have been reduced, staff have been cut, and indigent patients have been asked to contribute more to the cost of services. The irony of this is, of course, that reducing a program as effective and cost-efficient as Title X results in far greater social and financial costs down the line.

By providing modest increases in the authorized funding levels for basic family planning services, training programs and technical assistance program, enactment of S. 110 will permit the restoration of some services and the provision of preventive reproductive health services to additional clients.

An overwhelming majority of Americans (more than 90 percent) from all racial, socio-economic and religious groups, support the provision of publicly-supported family planning services. Over 80 national organizations

representing almost every segment of American life actively support Title X. Among the reasons for such a widespread support are that all persons should be able to freely determine the number and spacing of their children, that the timing and spacing of births has a direct impact upon the well being of mothers and children, and that the availability of family planning services can be instrumental in preventing or alleviating poverty.

In addition, the Congress has demonstrated broad bipartisan support for Title X despite its inability to pass a reauthorization bill. Congress has repeatedly refused to accept the current Administration's proposal that Title X be repealed and that family planning funds be rolled into a discretionary block grant to the states. This consistent reaffirmation by Congress of the need to maintain Title X as a categorical grant program has ensured national standards of care and service provision and is symbolic of the widespread public support the national family planning program enjoys.

S. 110 further proposes some modifications to Title X programs. The minor programmatic changes proposed in S. 110 will ensure the collection and analysis of appropriate data; more clearly define the type of research projects that should be funded to investigate methods to improve service delivery; assure the continued clinical training of family planning nurse practitioners; and remove from the statute an unnecessary funding provision that has never been utilized.

NFPRHA also strongly supports the two major initiatives described in S. 110, which will be further discussed in other testimony. Additional funding for

Senator ADAMS. Thank you, Dr. Kring.

I am going to go right to you, Ms. Wattleton, but I had one question that I wanted to bring up, and I have been searching through my notes here because it involves a policy question and it is based on data.

Your data is not similar to that which I received from the secretary, the first witness. I don't want to misquote her, but I believe she stated that even though poverty levels may have increased, pregnancies had decreased or the use of the family planning system is decreasing.

And I believe you just testified that they had cut off all the data in 1983. Now, if they cut off the data in 1983, what she just said to me is not very impressive to me. I wish she were still here because I didn't know you were going to say that.

That leads to a policy question that I am turning over in my mind. If you are becoming poorer and poorer, do you have fewer and fewer children because you are aware of your circumstances being much worse and therefore are more desperate or is it that there is simply no data and that what generally happens with the poor in this country, pertains. In this case, as the poverty level increases teenage pregnancies increase and the whole panoply of difficult social problems increase.

Now, did I quote her wrong?

Mr. KRING. I was somewhat shocked when I heard her statement, too. And when she referred to a lower poverty rate in the Northeast, I thought I wonder why she didn't quote the West where the poverty rate has increased drastically, the number of women in poverty, and why she didn't quote the national statistic that today the birth rate among women of poverty is higher than it has ever been in history.

There are more children being born today to women below 100 percent of poverty or in the poverty level than ever in the history since we have had poverty levels in this country.

That is from the national data, not from data collected by the Office of Population Affairs.

Senator ADAMS. I won't take more time now, Mr. Kring, because I do want to hear from Ms. Wattle Ton and I know that Senator Kassebaum has questions.

Senator KASSEBAUM. The questions I have, Mr. Chairman, could be answered by both.

Senator ADAMS. So please, but I will ask staff to submit a written question or two so that I can get which way it is.

I think I know, but I just want to be sure I have that in writing.

[Responses provided by Mr. Kring for Nabers Cabaniss to questions submitted by Senator Adams follows:]

ADDITIONAL QUESTIONS FOR NABERS CABANISS FROM SENATOR ADAMS

Question 1. Is it true that BCRR data on numbers of individuals served do not fully differentiate between Title X funded services and other federally funded medical services in a given setting? For example, don't Maternal and Child Block grant services show up sometimes as Title X services, and vice versa?

Answer 1. Title X projects receive financial support from a variety of sources in addition to Title X. These sources include the Maternal and Child Health Block

grant, Social Services Block grant, Primary Care (Sections 329 and 330 of the PHS Act), Medicaid, State and local funds, private insurance, patient fees and donations. The same level and quality of services are available to all clients of an individual Title X funded project without regard to the source of payment. Since the initiation of the BCRR system, BCRR data on numbers of individuals served in Title X projects have included all clients served in the projects regardless of the source of payment for the services.

Question 2. Is it true that BCRR data do not reflect services delivered to men?

Answer 2. Reporting requirements for male family planning patient counts were dropped from the BCRR in 1982 as part of an effort to reduce information collection burden which had precipitated a very careful consideration of each question asked on any Federal Government reporting form. A number of reasons caused male counts to be dropped. 1) Because male family planning patients are a very small proportion of all family planning patients, information on male counts was thought to be less valuable than other information which remained on the reporting forms. 2) Male services are usually either an adjunct to female services or involve condoms or a sterilization. Condom supply or resupply does not qualify as a medical visit on the BCRR system. Sterilization is an expensive procedure which is rarely provided directly within Title X projects. As such, male services are not comparable to female services, which often involve regular returns for medical examinations or other services.

Question 3. Is it true that BCRR data do not reflect visits for counseling, only those for medical services?

Answer 3. BCRR data does include data on clients who received services other than medical services if a client record was established and the visit was recorded. For example, Natural Family Planning users are included even though the only services they may have received were education and counseling and even though they may not have received any specific medical services. On the other hand, clients who merely participated in a group counseling or education session and from whom no medical data were collected or record established would not be counted in the BCRR system.

Question 4. What percentage of the eligible population do you feel Title X clinics served in the most recent fiscal year for which data were available?

Answer 4. According to estimates from the Alan Guttmacher Institute, in 1987 there were 7.9 million low income women in need of family planning services. Estimates from the Bureau Common Reporting Requirements (BCRR), also for 1987, show that 3.7 million women with comes at or below 150 percent of poverty were served by Title X programs. Thus, nearly one half of the in-need population received services from Title X. Of those low income women in need who were not served by Title X, an unknown proportion received services from other private physicians, family planning clinics not funded through Title X (including projects which do not receive Title X funds, but are funded by Maternal and Child Health Block grant, Social Services Block grant, Medicaid, State funds or other sources) or used over-the-counter methods or natural family planning. In addition, an unknown number of women choose not to seek or to use family planning services.

Question 5. Are you aware of a congressional mandate requiring annual reports of the number of people served by Title X? When can we expect to see such a report?

Answer 5. Since 1984, the Family Planning and Five Year Plan has been incorporated into a consolidated report, Report to Congress—Administration of the Public Health Service. The Office of Population Affairs has prepared the family planning section of this consolidated report each year, as required by Title X legislation, but the consolidated reports for fiscal years 1987 and 1988 are still under review. Because of your expression of interest, this issue has been discussed and these reports will be given expedited review and submitted promptly.

Question 6. Logically, as you suggested, if an adolescent were actually abstinent, that would be the most effective way to prevent pregnancy. By my question is whether ALA programs have generated any empirical data demonstrating the relative effectiveness of abstinence proportion programs compared with other strategies for preventing adolescent pregnancy? Which program or programs generated such data?

Answer 6. Each AFL demonstration project has an evaluation component which is conducted by an independent evaluator, usually affiliated with a university located in the same State as the project, as required by the legislation.

Evaluation of prevention approaches is not a well developed science. Measurement of prevention program objectives—postponement of sexual activity and preventing pregnancy—is inherently difficult and, in many cases, imprecise. Because of the sensitivity of questions dealing with sexual activity, other measures are fre-

quently used which are known to correlate with decreased levels of sexual activity. Other program strategies for preventing adolescent pregnancy, such as sex education and family planning programs for adolescents, of course face many of the same methodological difficulties.

Nevertheless, evaluations of some AFL prevention projects have shown promising results. For example:

Postponing Sexual Involvement, a prevention curriculum developed at Emory University with AFL support, has been found to result in substantially fewer participating teens becoming sexually active than in the comparison group. This curriculum has been adopted for use in school districts throughout Georgia, and is being used in North Carolina, Florida, and Michigan. Preliminary results indicate that the curriculum has been successful in reducing sexual activity among students. Evaluation results on use of the curriculum with low-income, Black eighth graders indicate a marked difference in sexual activity between control and treatment groups. Clients exposed to the curriculum are much less likely to have engaged in sexual activity than the controls at annual follow-up points.

Values and Choices is a prevention curriculum developed by Search Institute, Minneapolis, MN, and field tested in public schools in nine sites in Colorado, Michigan, Minnesota, and California with AFL support. Evaluation of this intervention showed significant pare- and post-test changes in students' attitudes and intentions in a number of areas. These include decreased intention to engage in sexual activity while a teenagers; increased awareness of the risk of sexually transmitted diseases; increased likelihood of agreeing that teen sex is against their values, and increased frequency of discussions with parents concerning sexuality.

Responsible Sexual Values Program (RSVP) is a program aimed at developing self-esteem and decision making skills among pare-teens in order to help them make decisions to abstain from early sexual activity. Preliminary results show that participants in the program develop better communication with their parents, improved knowledge about human sexuality and stronger attitudes about the positive values of abstinence.

AANCHOR is a curriculum developed at Brigham Young University. Evaluation studies show that students participating in the program score higher on family strengths and on communicating with their parents about sexual beliefs and values.

Sex Report, a project focused explicitly on promoting teen abstinence, is being demonstrated in schools in Illinois, Kansas, Missouri, and Wisconsin. Evaluation of Sex Respect shows that participants have increased approval of the value of not being sexually active, feel more strongly that stopping sexual involvement once having become sexually active is possible and desirable, and are more aware of the risks and consequences of engaging in sexual activity. Results available to date indicate that the program appears to reinforce the idea that marriage is the appropriate context for sexual intercourse. Program participation is also associated with heightened awareness and concern about the risks and problems associated with teen sexual activity. Positive changes in adolescent sexual behavior are also being observed in addition to changes in attitudes and values.

Senator ADAMS. I apologize, Ms. Wattleton, for your waiting a minute. Please, would you proceed.

Ms. WATTLETON. That's fine. I just want to reiterate Dr. Kring's point that the family planning program dismantle its data collection program a number of years ago. So that it does not have the kind of data that would give more precision with respect to the services that are offered on the women in need. I am here today testifying on behalf of more than 30,000 volunteers and staff members of the Planned Parenthood Federation, representing 176 affiliates in 46 States and the District of Columbia.

Last year, we served over four million women and men in our affiliates, and I thank you today for hearing my testimony.

I want to build on the testimony of the two people who preceded me, Dr. Federman and Mr. Kring. And I, however, want to talk a little bit about the political attacks on the Title X program. I want to make the distinction that we are talking about Title X here today, we are not talking about an attack on Planned Parenthood or a program that is exclusively for the purpose of funding Planned

Parenthood. Only 25 percent of Title X funds go to Planned Parenthood clinics.

From its earlier days, Title X enjoyed bipartisan support in this Congress, primarily because Senators and Members of the House of Representatives recognized that it really was the single most effective program that addressed the health and welfare of mothers and children in a very direct way.

As a matter of fact, there was once upon a time a very liberal Republican Congressman from Texas by the name of George Bush who was quite supportive of Title X. We wonder what has happened over the past years.

I don't have time to detail all of the attacks and the political harassments and administrative confusion that have occurred. But I would like to thank this committee and other members of the committee who are not here for their continuing faith in the program that has shown itself to be so successful and to have such a great impact.

When DHHS proposed sweeping new regulations to ban the provision of any information about abortion services in Title X clinics, it was really only one of many attacks that have occurred over the last 8 years. Those attacks commenced with the inauguration of Mr. Reagan and they have continued. They have resulted in repeated lawsuits, year after year, the most recent being the lawsuits that have been brought against the so-called gag rules. Three lawsuits, in fact, have been filed in Federal district courts challenging the constitutionality of these new regulations that would prevent family planning programs from offering women balanced information about their options when they face an unintended pregnancy.

To date, the regulations have been struck down by courts in Denver and Boston, with judges finding them illegal on constitutional grounds. The New York court found a history of DHHS approval of non directive counseling—that is, counseling for a woman to help her decide for herself what decisions she made—but decided that the agency could change its longstanding interpretation of the Title X statutes.

The regulations are currently in effect, and those Title X recipients who are covered by these court orders, who are covered by Planned Parenthood and NFPRHA. However, yesterday an appellate court in Boston sustained the lower court rulings.

This untenable situation makes it clear just how badly the Title X statute needs to be reauthorized, reaffirming its long history of complete, non directive information for women as well as teenagers. The record should not be ambiguous on that point, it should be perfectly clear.

Family planning clinics have not only been forced to fend off the many and unending array of political attacks on the program, they have also been struggling under the budget constraints that you have heard about. Planned Parenthood also supports S. 110 as an important first step in restoring the adequacy of funding for the Federal family planning program.

Given the current budget deficit, we know that there are restraints, but we also know that an investment in family planning can reduce the need for an investment in costlier social and health services to the Government. It is vital that a continuing effort be

made in providing sufficient levels of funding and to begin the restoration that has been the cause of an erosion in the programs, a part of the destructive policies of the Reagan administration.

We support S. 110, which authorizes $163 million for services to start in 1990, as a first step in that direction. At the same time, while the basic core of the Title X program is restored, there are other steps that need to be taken that will truly enable women and young men who come into the program to make decisions and make them on an informed basis.

We believe that it is important to realize that a variety of methods are widely available to women and couples in countries throughout the world that are not available in this country. And therefore, we call for better birth control in the United States. S. 110 would authorize $10 million for a contraceptive development initiative aimed at boosting the research already conducted by the National Institute of Child Health and Human Development.

Seven years ago, in 1982, the Office of Technology Assessment recommended that an additional $20 million be allocated annually for contraceptive technology. Yet, last year only $9 million was slated. So we think that this is a modest move in the right direction. We need better and safe methods of contraception.

Along with better methods of contraception, women, teenagers, and their partners need better information about the means to prevent unintended pregnancy and sexually transmitted diseases, including AIDS. And to that effect, we support the expansion of community-based education and outreach programs in S. 110.

This new initiative to assist in the development of more education for young people and their parents—and I might add a plug that Planned Parenthood has published a book titled "How to Talk to Your Child about Sexuality." So we have long been on record as desirous of helping parents to do a better job of educating their children.

But as a matter of policy in this program, to add this initiative to give parents more tools to work with their children to enable them to negotiate the perilous difficulties of developing sexuality is a very laudable objective indeed.

In closing, Mr. Chairman, Planned Parenthood's primary mission is to enable all Americans to have the information and the ability to prevent unwanted and unintended pregnancy so that individuals can achieve their family size based on their own wishes, not the wishes of others or the imposition of their Government.

High-quality, low-cost services offering the safest and most effective methods are essential to achieving this goal. An unplanned pregnancy is indeed a national problem demanding a continuing national approach.

We appreciate the opportunity today to testify before this committee, and we look toward to working with you toward the successful enactment of this reauthorization.

Thank you.

[The prepared statement of Ms. Wattleton follows:]

PREPARED STATEMENT OF FAYE WATTLETON

INTRODUCTION

I am Faye Wattleton, President of Planned Parenthood Federation of America (PPFA). On behalf of the more than 30,000 volunteers and staff who operate our 176 affiliates in 46 states and the District of Columbia, the 250,000 individuals who contribute to our organization, and, most important, the more than 4 million women and men who are served by our affiliates each year, I thank the committee for asking me to participate in this hearing.

At the committee's request, my remarks this afternoon will focus on the recent political attacks on the Title X family planning program, and specifically on the status of the lawsuits challenging the Reagan administration's Title X regulations. In addition, I will be addressing the two program initiatives proposed in the Title X reauthorization bill we are considering today, which are designed to buttress and improve the provision of basic contraceptive care: the special initiative on contraceptive research and development and the proposed expansion of the information and education section of the statute to encourage the development of community-based educational programs aimed primarily at teenagers and parents.

THE PROGRAM AND ITS POLITICS

From its earliest days, Title X enjoyed bipartisan support. Democrats and Republicans in both houses of Congress embraced the concept -- and supported the program -- of using government resources to make voluntary family planning available as a tool to enhance the health and welfare of mothers and children, through the prevention of unintended pregnancy.

Members on both sides of the aisle, and on both sides of the abortion question, also embraced federal support for family planning as the single,

most direct means available to reduce the need for abortion among women in this country. (One of the early, vocal supporters of the program was a Republican Congressman from Houston, now President George Bush.) Given this history, it is hard to comprehend the hostility directed towards the Title X program in the recent past.

Yet, since Title X was reauthorized under the Omnibus Budget Reconciliation Act of 1981, the program has been subjected to both political harassment and administrative confusion. Thanks to the efforts of the program's congressional supporters, and to the basic strength of the program itself, Title X has largely withstood this array of assaults. But they have taken their toll, and the open attacks on Title X that have been ongoing since 1981 must end.

The first such attack came in President Reagan's 1981 budget request to Congress. He proposed that year, and every year during his administration, to eliminate the federal family planning program entirely. First, he proposed a primary care block grant under which there would no longer have been a specific mandate to fund family planning services at any level. Later budget requests took a slightly different tack, placing family planning services alone in a block grant to the states, with no federal standards on informed consent, confidentiality or the types of services to be offered. It is regrettable that President Bush's first budget makes the same proposal.

These budgetary attacks were followed in 1982 by the ill-fated parental notification regulations. The DHHS effort to require federally funded family planning clinics to notify parents by registered letter if their minor daughters sought prescriptive contraceptives drew a storm of protest from

nearly 100 national organizations. When DHHS went ahead and promulgated the regulations anyway, federal courts barred their implementation and struck them down on grounds that they were inconsistent with both the letter and the spirit of the Title X statute.

In 1983, the day to day administration of the Title X program was abruptly transferred away from public health professionals and placed under the direct control of the Deputy Assistant Secretary for Population Affairs (DASPA), a hostile political appointee. Although we support the position of DASPA for overall policy coordination with other DHHS programs complementing Title X (services under Medicaid, maternal and child health, social services, research at the National Institute of Child Health and Human Development, evaluation at the Centers for Disease Control and the Food and Drug Administration), we oppose the isolation of Title X on political grounds from the other primary care and maternal and child health programs in the Health Resources and Services Administration. Despite congressional mandates to the contrary, the program continues to be administered directly by the DASPA.

In 1986, under then-DASPA Jo Ann Gasper, the tenor of administration attacks on the Title X program intensified dramatically. Mrs. Gasper subjected the Title X program to an unprecedented series of actions designed to accomplish by administrative fiat what Congress has repeatedly refused to do through legislation.

In the summer of 1986, at Mrs. Gasper's instigation, DHHS Secretary Bowen announced plans to change the Title X guidelines to make it optional for Title X grantees to provide pregnancy options counseling and referral to women facing an unintended pregnancy. This attempt to change the program

administratively followed two unsuccessful legislative attempts to disallow counseling and referrals for abortions in Title X programs, and provoked a directive from the Congress (in the report accompanying the FY 1987 continuing resolution) prohibiting the administration from making changes in the Title X program.

Stymied but apparently undaunted, Mrs. Gasper issued an unauthorized "program instruction" in January 1987 ordering the regional administrators of the Title X program to defund Planned Parenthood affiliates and other organizations that "promote abortion." Her order was rescinded and she was reprimanded and later fired.

A short time later, however, Nabers Cabaniss was appointed to run the program, and, on September 1, 1987, DHHS formally proposed sweeping regulatory changes in the Title X program. The primary purpose of the new regulations was, of course, to wipe out longstanding DHHS guidelines, which require the provision of non-directive problem pregnancy counseling when requested, and to ban the provision of <u>any</u> information about abortion in clinics supported by Title X funds; this ban is coupled with compulsory referrals of all pregnant women for maternity care. Thus, the new Title X regulations are designed to compel family planning providers to make the difficult choice between offering only government-approved information to pregnant women, or foregoing federal funds. DHHS moved to promulgate these regulations in final form on February 2, 1988, despite the opposition of 36 state governments, 78 national organizations (including every major national medical association) and the deans of all 25 schools of public health in the country.

Three lawsuits were filed in federal district courts challenging the constitutionality of the new Title X regulations. Two of the lawsuits cover the majority of Title X grantees; the Planned Parenthood Federation of America's litigation in the Denver court covers all of its affiliates which receive Title X funds, and the case brought by the National Family Planning and Reproductive Health Association (NFPRHA) in Boston applies to most of the other family planning grantees. The third case was filed on behalf of the city and state of New York. To date, the regulations have been struck down by the court in Denver and Boston, with judges finding them to be both illegal and unconstitutional. The district judge in Boston said, "In its attempt to implement a health care policy which promotes childbirth, the defendant has devised a system which rests in large part on keeping Title X clients in ignorance." And in Colorado, the court wrote:

"...the regulations violate (1) a woman's Fifth Amendment liberty interest in choosing whether to have an abortion, (2) her First Amendment right to receive necessary medical information to enable her to vindicate her Fifth Amendment liberty interest, and (3) a physician's or other treating practitioner's First Amendment right to disseminate necessary medical information to patients."

The New York court found a history of DHHS approval of non-directive counseling, but decided that the agency could change its longstanding interpretation of the Title X statute.

The regulations are currently in effect for those Title X recipient agencies not covered either by the Planned Parenthood or NFPRHA lawsuits, including recipients of family planning funds in New York. However, all three

decisions are on appeal before federal circuit courts. In the meantime, as individual Title X grantees' budget renewals come up, the regulations may be enforced against those not otherwise protected by a lower court order. This untenable situation makes it clear just how badly the basic Title X statute needs to be reauthorized, reaffirming its long history of complete non-directive information and services.

INITIATIVES AND RECOMMENDATIONS

In 1981, the Title X program (as well as most other domestic programs) suffered a drastic cut in appropriations, from $166 million to just below $125 million. This year's appropriation of $135.1 million for basic services is thus $30 million below FY 1981's level, not even adjusting for inflation. Conservatively accounting for inflationary increases alone, the current level of Title X funding should be over $230 million for fiscal year 1990. As a result, family planning clinics have not only been forced to fend off all the political attacks on the program but also have been struggling under severely strained budgets.

DHHS estimates that as many as 1,000 clinic sites have closed since 1982 for lack of funding, although in the absence of reliable program data, which DHHS has not collected since 1983, it is impossible to know for certain.*

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*There is a continuing serious deficiency at DHHS in collecting and analyzing national program data. After terminating its long-standing contract with The Alan Guttmacher Institute in 1983, DHHS stated that it would conduct these activities itself. Yet, the fact remains that none of this information has been collected or analyzed since that time. Thus, we have no up-to-date information on how many of these women are being served in federally funded family planning clinics, or even how many clinics are in operation. During a time of careful attention to government spending, it is critical to have this

It is clear, however, that numerous special projects have been discontinued by many agencies, including male involvement and community education and outreach, among others. In order to preserve the core of the program -- the provision of basic contraceptive services to as many individuals as possible -- clinics have had to diminish their information and education activities. These activities are not frills, however, and their discontinuation has had detrimental implications not only for teenagers, but for adult women in light of the extent of public misinformation that exists about current contraceptive methods. It will certainly guarantee a continuation of the high level of unintended pregnancies in this country.

Title X is the only health program which has not, in monetary terms, recovered from the budget cuts of 1981. And yet the need for contraceptive services and information continues to grow. Almost 32 million women in the United States are currently at risk of unintended pregnancy and, thus, in need of family planning services. Just over 13 million are low-income adult women or sexually-active teenagers -- almost three times as many as the five million thought to be served currently in family planning clinics across the nation.

Planned Parenthood supports S. 110 as an important first step in restoring adequate funding for the federal family planning program. Given the current budget deficit, we realize that the restoration of funding levels adequate to meet the need that exists will not happen overnight. However, it

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information both for congressional oversight and in order for DHHS, and local program managers, to allocate funds where they will be most efficiently spent. Therefore, we urge the committee to ensure that DHHS follows through on this commitment; program accountability is crucial to the program's success and future direction.

is vital that continuing efforts be made to fund Title X at levels ensuring the continuation of services now being provided, with substantial progress made towards an expansion of services to the millions of women and teenagers in need who are currently not being served. This investment is necessary because of austerity, if more costly services are to be avoided. S.110, which authorizes $163 million for family planning services in FY 1990, is a step in that direction.

At the same time, while the basic core of the Title X program is being restored, there are other steps which need to be taken to carry out the original intent of the family planning program -- making voluntary family planning services widely understood and available to all who need and want them. The two modest program initiatives embodied in S. 110 are small but necessary expansions of the current statute, which will serve to improve contraceptive use and buttress the basic services already offered.

The first initiative would authorize $10 million for a contraceptive development initiative aimed at boosting the research already being conducted at the National Institute of Child Health and Human Development (NICHD). Contraceptive use -- while nearly universal in our society -- is often imperfect not only because human beings are imperfect but also because of the imperfections of existing methods. The inadequacy of available contraceptive methods is reflected in the fact that more than half of the approximately six million pregnancies that occur each year in the United States are unintended. Moreover, it is important to realize that a variety of methods widely available to women and couples in other countries cannot be obtained here for a variety of reasons, among them insufficient public funding for continued

research and evaluation, a product liability crisis that has resulted in the fact that only one private pharmaceutical company in the United States is now conducting new contraceptive research, the spillover from abortion-related politics, and cumbersome FDA regulations.

Federal support for development of new or improved methods, as well as for the evaluation of the safety and effectiveness of current ones, has actually declined since FY 1981. This has occurred in spite of the fact that, seven years ago, the Office of Technology Assessment (OTA) recommended an additional $20 million annually in federal funding for contraceptive technology, noting that available research opportunities are only waiting to be exploited.

Title X authorizes research in the reproductive sciences, social and behavioral studies, contraceptive development and contraceptive evaluation. NICHD administers all these areas of research, and is the leading entity worldwide performing this type of research. Yet, all areas of population research together were funded at only $128 million last year, with a mere $9 million slated for actual contraceptive development. We need new safe, effective and acceptable methods of contraception, and we need to reassure ourselves about the safety and efficacy of current ones. This is not a field for which a single, even a massive injection of funds would be adequate. Rather, steady and reliable funding at a modestly higher amount could bring some of these leads to fruition. We applaud NICHD's initial efforts in this area, and we strongly support the new authority for contraceptive product development outlined in S. 110 which would further the process of making ready for public use contraceptives which are well along in the development process.

Along with better methods of contraception, women, teenagers and their partners need full information about available methods before deciding which is most appropriate for them at each stage of their lives. The second initiative contained in S. 110 would reauthorize the information and education component of Title X, placing expanded emphasis on the development of community-based programs designed primarily to reach out to young people and their parents, to help them to communicate with each other, and to help young people make responsible choices concerning sexuality, pregnancy, and parenthood, including whether to be sexually active at all at a particular time.

This initiative already has been attacked by Title X opponents and even labeled by some as a front for getting federal funding to school-based health clinics. Instead, I would submit that it may be the most realistic and constructive way to expand and enhance genuine parental involvement in family planning programs. This new initiative would enable interested communities to develop their own information and education programs, targeted and tailored to their own needs. In many communities, these project grants could alleviate some of the other cutbacks made to education and outreach efforts, unfortunately made necessary because of overall funding reductions. Although the provision of basic family planning services must remain the top priority within Title X, we strongly endorse this initiative because of its potential use in facilitating and increasing communication about family planning services, particularly among adolescents and their parents.

CONCLUSION

Mr. Chairman, Planned Parenthood's primary mission is to enable all Americans to have the information and the ability to prevent unwanted or unintended pregnancy so that individuals can achieve their own family size goals. High quality, low-cost services offering the safest, most effective and most acceptable methods are essential to achieving this goal. Unplanned pregnancy is indeed a national problem demanding a national solution. We look forward to working with you now and in the future in sustaining and heightening the importance of preventive, voluntary subsidized family planning services for those in need and the pursuit of better contraceptive technology for all of us, in the United States and around the world.

Senator ADAMS. Thank you, Ms. Wattleton.

I have only one or two questions, and then I will submit any others that I have in writing.

One question goes back to the same question that I asked Dr. Kring, in your prepared statement you also indicate that there was a cutoff of data in 1983 by the department that was supposed to be supplying us with data as to how effective the program was. Is that correct?

Ms. WATTLETON. Correct.

Senator ADAMS. Yes. Well, I asked the question regarding the effectiveness of abstinence because I have heard statements that this was supposed to be a great deal more effective. I just can't see how we can be making such a judgment if the data that is the basis of it has been cut off.

Ms. WATTLETON. Well, the data for family planning programs, the national data as collected by the Office of Family Planning, was discontinued. This has been a source of great concern to us because we believe that it was a part of an overall strategy to dismantle and render the program ineffective: if you don't collect data, any number of charges can be leveled against it and you don't have the data to refute those charges.

So as a longtime family planning provider, starting in family planning programs almost 20 years ago, I recognize the seriousness of the deficiency and your frustration in dealing with the issues because the data collection has been discontinued.

Senator ADAMS. That brought me to my second question, which was, you were here and heard the comments that were made about no information being given to a potential person who had appeared at a family planning clinic with regard to conversations or revealing this to parents.

Now, that has certainly not been this Senator's experience with family planning clinics, and I have been, like most Senators and Congressmen, in just about every kind of a family planning clinic and so on imaginable throughout the country.

Is that a standard procedure? You indicated there was a booklet that you regularly distributed to those who came to the clinic, indicating that there was an advantage in discussing this with their parents and that this was encouraged but not required?

Ms. WATTLETON. Yes, Senator. I respectfully submit that the accounting that you heard today may be that experience of the young woman, although there were a number of points in her statements that were confusing; namely, that she indicated that she was referred the next day to a hospital clinic. So I am not sure exactly where one started and the next one began. She went to Planned Parenthood for counseling and then she was referred to another clinic for examination.

I can only state that we are in the business of the provision of ethical health care services. We would consider it unethical to not discuss with any client who comes in, and it is against the Planned Parenthood standards to not discuss with any client that comes in, all of the methods of birth control and fertility management, including abstinence. We want people to make decisions from their own bases of information and their own moral framework, and we don't seek to impose a moral judgment about their views.

We don't want them to undertake the responsibility of parenthood by happenstance. We want them to understand the options available to them and the means that they have available to them to carry out those options.

That is why we are in court challenging the Government's position that certain information should be withheld from women. Why else would we challenge that save but that we want women to be fully informed and to make informed and thoughtful choices.

We also believe in confidentiality. One of the features of family planning and Planned Parenthood clinics is that people do come to us because they know that we will not divulge information about them but that they must go with the information and decide how to make these decisions and carry them out for themselves. And that is certainly what any woman who would come, or man for that matter, who would come to a Planned Parenthood clinic would receive.

Senator ADAMS. Thank you very much, Ms. Wattleton.

Senator KASSEBAUM. Thank you, Mr. Chairman.

This is a question either one of you can answer. Title X states that to the extent practical, entities which receive grants or contracts shall encourage family participation. That is a part of the Title X language.

What efforts are made in counseling to encourage teenagers to involve their parents, let's say, in California?

Mr. KRING. I can give you California specifically, although I assume we are not unique.

We do training in terms of parent-teen communication extensively. Each chart and each protocol must discuss in counseling with the teen prior to receiving any services that the teen has had discussions regarding communication with parents, regarding family involvement if they choose so. If the teen says no way can I communicate, they are certainly not forced and told you must go home and communicate.

But they are indeed, they do indeed receive counseling saying you need to have another adult you can talk to, if there is another person you can talk to, whom can you communicate about why you are here. And if no one, then we encourage them to at least find another adult in those cases.

Every chart of every adolescent has to show when we go in and do quality assurance audits, every chart of every adolescent has to show counseling according to protocol for adolescent family involvement. And we monitor that very closely in our clinics to make sure that the counselors have received training and are indeed following the guidelines in terms of dealing with family involvement.

Senator KASSEBAUM. Let me just follow up a bit on California. Do you emphasize family participation? Do you emphasize contraceptives? Is there any particular emphasis, or is it the counselor's own decision as to what would best assist a client?

Mr. KRING. I can't say specifically in every clinic. I think it varies from clinic to clinic. Many of our clinics do have—we have peer educators, which are usually thought of as teens. In many of our clinics, the peer educators are adults who are actually parents of teens, who are working with other parents to help them learn

how to deal with their teens and how to communicate effectively with their teens about sexuality.

So we are doing education both ways, not just with the teen that comes in, but with the parents and the community also.

Senator KASSEBAUM. Well, I think that is very important.

Mr. KRING. And that has been a unique and very successful program in terms of getting parents to work with other parents.

Senator KASSEBAUM. Well, I have found sometimes that parents just don't want to assume responsibility, and would just as soon not know, as a matter of fact.

Mr. KRING. I think that is more often with the teens, it is oftentimes the teens attempt in various ways to tell the parents that they are being sexually active or that they want to be sexually active and the parents don't want to know.

I have two teens—or I have two past-teens now. My son told me one day, he said, "Dad, you know, you never really talked to me about sex," and I about died. [Laughter.]

And then he pointed out how he tried to bring up the subject, and as educated as I am I had blown it on several cases, he felt, in terms of communicating back with him.

Ms. WATTLETON. I think we sometimes forget that over 50 percent of the teens who come to family planning clinics come with their parents 'knowledge. Some of them come, in fact, to clinics with their parents.

Planned Parenthood has a number of programs and resources for parents because I think it is also important to keep in mind that the maximum number of hours that a young person or a woman, for that matter, will spend in a family planning clinic in a given year is probably two or three. So the potential for impact on that individual's behavior of decision making is very limited and it must be very highly focused.

Teenagers do know what the relationship with their parents are before they come to a family planning clinic, and the best that we can do is to try to reinforce the need to have family communications, but not at the risk of divulging confidential information that would not be appropriate.

Our emphasis—and that is why we support the community-based aspect in this bill for educations that parents must start before kids are sexually active. It's a little too late, as the Alan Gutmacher study has found that was released this past week among sex education teachers in schools, that when they start the effort, it really is very late. And so we want to be a resource and we hope that this will be a policy that will help parents to become aware of their responsibility before the days of tension; that is, when sexual maturation moves into full bloom and decisions around sexual intimacy are being made.

Senator KASSEBAUM. Well, in most public education programs that have been designed for, say, grade school—even in beginning sexual education programs—parents have to participate.

Ms. WATTLETON. Those are the most successful, but unfortunately, Senator, there are only 13 States that require sexuality education programs, comprehensive from kindergarten through twelfth grade in this country. We are not a society that does a very good job of sexuality education or involving parents in that process as a

Nation. And I think that every effort that we can make to move toward that initiative, to help parents undertake this responsibility before sexual activity commences, the better off we will be and the better our children will be.

I am very keenly sensitive to that because I have a 13-year-old. While she goes to a girls school, I know that these issues are still very much on her mind, and I too recognize the dilemmas that we face as parents.

Senator KASSEBAUM. Well, it is difficult. In my day we just had biology class and we didn't get into all of this. [Laughter.]

But times have changed, and so one has to be sensitive to a lot of these considerations.

But let me just ask you, if you believe in encouraging parental involvement, and I think we all do in this instance, and in all things, what's wrong with requiring parental consent for using family planning services?

Mr. KRING. I will give you an example, and this is an extreme example but it happened when I was director of a clinic in northern California. This didn't involve consent, it involved communication, and we really pushed hard for parental communication with our clients at that time, feeling that everybody needed to talk and that parents really aren't as bad as teens think they are.

So we did role playing with the kids, and somebody would take the role of parent and really try to get them to communicate and to be able to say I can go home and talk to them.

I go to work early, always have, and I got in early, about 7 a.m. the next morning, and there was a teenagers outside our door who was black-and-blue, with a suitcase, and said, "I took your counselor's advice. I went home and told my parents that I came here and got contraceptives. My dad beat me and told me I can't live at home anymore. What do I do now?"

I think the fact that there are those type situations where teens need contraception and need care and need health care and don't come from a home environment where they could receive it, in fact where they will be abused, speaks against parental consent for receipt.

I strongly support parental communication and I strongly support encouraging teens in every way possible to discuss with their parents. I fear for bad relationships where there is not communication, period, such as there wasn't in this situation. That's it.

Senator KASSEBAUM. Thank you.

Faye, do you have any comment?

Ms. WATTLETON. No. He has said it very well.

Senator KASSEBAUM. Yes.

Thank you very much.

Senator ADAMS. Thank you both very much. We have appreciated your testimony, and we appreciate the time that you took to come here, and the committee is very grateful for your assistance.

Ms. WATTLETON. Thank you for having us.

Mr. KRING. Thank you.

Senator ADAMS. The next panel is panel number IV, which consists of: Stephanie Jones, a student in Baltimore, MD; Richard Glasow, of the National Right to Life Committee; and Caroline

Gaston, principal of the New Futures School, Albuquerque, New Mexico.

The committee welcomes all of you, and we appreciate very much your taking the time to appear. Why don't we start, Stephanie, from right to left and move right down the table. I know that Senator Kassebaum does have some questions for you had has another engagement. So why don't you start with your testimony, then we will proceed with the entire panel, and I will question all of the panel at once. I will not question you until we have completed the panel.

STATEMENTS OF STEPHANIE JONES, STUDENT, LAURENCE PAQUIN SCHOOL, TITLE XX GRANTEE, BALTIMORE, MD; DR. RICHARD D. GLASOW, PH.D., EDUCATION DIRECTOR, NATIONAL RIGHT TO LIFE COMMITTEE, WASHINGTON, DC; AND CAROLINE GASTON, PRINCIPAL, NEW FUTURES SCHOOL, ALBUQUERQUE, NM

Ms. JONES. Good afternoon, Senator Kassebaum and Senator Adams and other members of the committee. My name is Stephanie Jones, and I am pleased that the Child Welfare League of America contacted me to present testimony at this important hearing.

I am 17 years old and a single mother of a daughter, Jessica, who is 1 year and 2 months old. I was 15 years old when I became pregnant, and my baby was born when I was 16 years of age. Jessica's father is 24 years old and serves in the United States Army. He provides financial support for Jessica and takes an active parenting role when he is home on leave.

I live with my parents, who have been married for 22 years, and I have two older sisters. My father works as a security guard, and my mother is a custodian at a public high school.

When I became pregnant, I was an A student at City College High School in Baltimore. One of the most difficult things I have ever had to do was to tell my parents I was pregnant. They were very disappointed and said they would be supportive of me, but I would have to be responsible for the care of my baby. They also expected me to continue my education.

The high school I was attending offered nothing in the way of counseling or referral for prenatal care or post pregnancy services. It was my family that provided the support and encouragement I needed to get through pregnancy and childbirth and also to look ahead to a bright future for my daughter and myself.

After Jessica was born, I became a student at the Laurence G. Paquin School, a public comprehensive high school for expectant adolescent mothers. Each year the school serves over 1,000 students between the ages of 11 to 20 and provides excellent prenatal and parenting programs for young mothers. One of the special features of the school is the on site infant and toddler center where the students' babies receive loving care and attention from a dedicated staff.

Since she was 6 weeks old, I have taken Jessica to school each morning where she is cared for in the infant-toddler center. I receive guidance and counseling on how to be a good mother, and I

spend time with my daughter during the day whenever my schedule permits.

On the weekends I work as a receptionist in an apartment building in downtown Baltimore. Most of the members of my family care for Jessica while I am working.

Next month I will complete the tenth grade. Because I have been in an advanced course of study program, I will enter the twelfth grade in September and will graduate in June 1990.

After graduation I plan to enter the United States Armed Forces and pursue a career in communications. This may sound like my life as an adolescent mother is a fairly easy one and that I have few problems. Let me assure you that it is not true. I had no idea of the amount of time, attention, and care I must give Jessica if she is to be a happy, healthy baby. Caring for her, trying to be a good student, and working part-time takes up every waking moment. Sometimes I feel very discouraged and depressed.

I have little time to relax or to have fun. But I love my baby and I know I have the responsibility for providing her and myself the best life possible. I can do this only if I continue my education and if I continue to receive support services.

I have been very fortunate as a young mother to have a family who gives me emotional and financial support and assistance in raising my baby. Jessica's father is also very involved in her life. In addition, I receive excellent support from my school principals and teachers. Most teenage mothers do not have these resources in their lives.

This is why Senator Kennedy's bill is so important. In the first place, it will provide adolescents with education about sexuality and family life in an effort to keep them from having babies. Jessica's father and I went to a clinic to learn about childbirth, birth control, and we used it, but not as we should have. Sex education is for adolescents who need it to be readily available, and teenagers should be encouraged to discuss information and services with their parents.

However, adolescents should be able to receive services without their parents' permission. So many parents are uncomfortable discussing anything that has to do with sex at any time, when their teenagers need the best information available.

If a teenagers does become pregnant, she needs the same kind of help I have been able to receive. Such services should be available for both parents.

It is very important for us to include the young fathers in the support services offered to adolescents. Sometimes we seem to forget that two parents make a baby and two people should share the responsibility of caring for the baby.

Adolescents should not become parents. I believe sex education will help us to make decisions that will prevent unintended teen pregnancies. However, when teens do become pregnant, they need all the help that they can get in order to make good, sound, strong decisions about their lives and the lives of their babies.

Senator ADAMS. Thank you, Stephanie, for an excellent statement.

Ms. JONES. Thank you.

Senator ADAMS. Did you wish to question at this time?

Senator KASSEBAUM. Thank you, Mr. Chairman. I will go without questions until we have completed the panel.

Senator ADAMS. All right.

Dr. Glasow?

Dr. GLASOW. Mr. Chairman, I am Richard D. Glasow, education director for the National Right to Life Committee, NRC. The National Right to Life Committee is the Nation's pro-life organization. We represent about 3000 local pro-life chapters. We are advocates for those innocent human beings whose right to life is threatened by abortion, infanticide, and euthanasia.

The National Right to Life Committee and its affiliates take no position on contraception, properly so called. Our members have viewed that run the gamut on that issue of contraception. We recognize, however, that Title X is currently a major source of funds for certain organizations which treat abortion as simply one birth control option among many.

NRLC has many concerns about the way that Title X has been implemented in the past. NRC supports the implementation of the regulations for Title X promulgated by the Department of Health and Human Services on February 2, 1988, which are currently under legal challenge. The regulations prohibit any abortion counseling or referral within projects funded by Title X.

Today I shall concentrate on proposed revisions to Title X contained in S. 110 which would promote abortion in two ways: funding of so-called school-based clinics, and research and development of abortion-causing drugs and devices such as the abortion pill RU-486 currently being used in France.

During the past several years, school-based clinics have engendered ferocious political controversy in communities from coast to coast. The language in section 8 of S. 110 would encourage the use of Title X funds for school-based clinics "to establish community-based information and education programs" to combat "unintended pregnancies" especially among teenagers.

Proponents of the bill have acknowledged that this provision would encompass the use of Title X funds for school-based clinics. I have spent over 4 years studying the literature and attending the professional conferences of the pro-school-based clinic movement, and the results were published last year in my book "School-Based Clinics: The Abortion Connection." Many pro-abortion advocates see abortion as the sensible remedy for unintended adolescent pregnancies.

These groups also see school-based clinics as an effective means to make abortion more readily accessible to pregnant adolescents without parental involvement and under the auspices of school authority. The result of Title X funding of school-based clinics would be federally mandated abortion counseling and referrals in our junior and senior high schools.

The Title X regulations currently in effect require all Title X grantees to counsel and refer for abortions and to do so confidentially; that is, without parental knowledge or consent when requested by the minor.

Thus, if Title X funds flow to a school-based clinic, any State or local rules regarding abortion services or parental involvement would be overridden by Federal Title X regulations.

Promoters of school-based clinics have endeavored to convince policy makers that the facilities are an effective means to reduce teenage pregnancy. In fact, as I point out in my written testimony and in my book, there is no empirical evidence that school-based clinics reduce teenage pregnancy rates. This lack of evidence was even acknowledged last year by one of the Nation's most prominent school-based clinic advocates, Douglas Kirby, director of research for the Center for Population Options. In a speech summarizing the results of a 3-year-long study of six representative school-based clinics, Kirby conceded that, "There is no measurable impact upon the use of birth control nor upon pregnancy rates or birth rates. This is all based on survey data. There is no measurable impact."

Beyond the school-based clinic issue, S. 110 contains other troublesome provisions, including section 7, which would permit the use of Title X funds to promote the development, evaluation, and bringing to the marketplace of new and improved contraceptive devices, drugs, and methods.

As I stated, NRC has no position on contraceptives, properly so called; that is, referring to devices which prevent the union of sperm and ovum. But NRC is also very much aware that some pro-abortion groups are attempting to stretch the meaning of the word contraceptive to include drugs such as the abortion pill RU-486, which is being used in France to induce abortions on women who are 4 to 7 weeks pregnant.

To prevent Title X funds from being used to promote RU-486 and such other drugs, it is necessary to amend S. 110 to exclude abortion-causing from the definition of the word contraceptive. During the 100th Congress, the prime sponsors of the bill refused to accept such a revision, thereby reinforcing pro-life concerns regarding the vague language of section 7.

In conclusion, the National Right to Life Committee is opposed to S. 110, as introduced, because it contains provisions which are likely to result in Title X funding of both abortion-promoting school-based clinics and abortion-causing drugs such as the French abortion pill RU-486.

I would ask, Mr. Chairman, that my written remarks be inserted in the record. Thank you, sir.

Senator ADAMS. Without objection, your entire statement will appear in the record as if read.

Thank you very much.

[The prepared statement of Dr. Glasow follows:]

PREPARED STATEMENT OF RICHARD D. GLASOW, PH.D.

INTRODUCTION

Mr. Chairman, I am Richard D. Glasow, Education Director for the National Right to Life Committee (NRLC).

The National Right to Life Committee is the nation's major pro-life organization. We represent about 3,000 local pro-life chapters. We are advocates for those innocent human beings whose right to life is threatened by abortion, infanticide, or euthanasia.

The National Right to Life Committee and its affiliates take no position on contraception, properly so called. Our members have views that run the gamut on the issue of contraception. We recognize, however, that Title X is currently a major source of funds for certain organizations which treat abortion as simply one birth control option among many.

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Today, I shall concentrate on proposed revisions to Title X contained in S. 110, which would promote abortion in two ways: funding of so-called school-based clinics, and research and development of abortion-causing drugs and devices, such as the abortion pill, RU 486.

SCHOOL-BASED CLINICS PROMOTE ABORTION COUNSELING AND REFERRALS, PRO-ABORTION EDUCATION, AND ABORTION PILLS

First, section 8 of S. 110 would amend Title X to authorize grants for "community-based informational and educational programs," such as school-based health clinics (SBC). The connection of the proposed amendments to SBCs was publicly acknowledged two years ago by a spokesman for the pro-abortion National Family Planning and Reproductive Health Association (the trade association and lobbying arm of the family-planning industry) in a remark about Senate Bill 1366, which carried language

identical to the current S. 110. In a story in the **Washington Post** on Wednesday, July 29, 1987, Scott Swirling, executive director of the association, acknowledged that the bill would indeed school-based clinics. His exact words were: "It is not the case that new research money will be going to [abortion-causing drugs] nor is the bill intended solely to fund school-based clinics" (emphasis added) (Rich 1987, A21).

S. 110 would authorize Title X funding for SBCs, and if a SBC received any Title X funds, the staff would be required--under the present guidelines governing recipient policies--to provide abortion counseling and referrals behind parents' backs, even over the objections of local officials.

Unfortunately, many policymakers and members of the public have unthinkingly accepted claims that SBCs do not promote abortion. Illustrative of the assurances routinely given the public was the statement that appeared in the Los Angeles Daily News attributed to Jackie Goldberg, the Los Angeles school board member who co-authored the proposal which established two clinics. "We don't intend to have an abortion referral service in the clinic," she said. "It's really sad how a good idea can be ruined by going around and yelling abortion," she lamented (Rifkin 1986, 1).

These claims are at best half-truths. Clinic supporters recognized several years ago that their pro-abortion policies and activities posed a potentially significant public relations problem. In an important article published in March 1985 summarizing SBC activities, SBC expert Joy Dryfoos observed that "the issue of abortion is frequently finessed in these clinics" (Dryfoos 1985, 75). This choice of words and the description of SBC policies found earlier in her article would alert the reader that SBC staff members are indeed employing a "subtle and tactful strategy" (to quote the dictionary definition of "finesse"). By being less than candid, SBC proponents were able to achieve their objective of arranging for abortions without arousing the indignation of either the parents--or community.

The careful reader will find in the speeches and publications of SBC proponents explaining clinic activities clear evidence that SBCs currently encourage abortion in two ways. First, school-based clinics exploit the authority of the schools to funnel a captive clientele of pregnant teens into abortion mills without parental knowledge or consent. Second, clinic staff members teach pro-abortion "sex education." In addition, the widespread establishment of SBCs could have dangerous future implications.

Critics fear that if SBC advocates are successful in carrying out their plans to open clinics throughout the country, the facilities could become distribution centers for the abortion pill, RU 486, if it eventually reaches the market in the United States.

Section One
SBCs Direct Involvement in Abortions

The principal pro-life objection to school-based clinics is that they "counsel" and "refer" pregnant girls for abortions. In this section, we will explain what those terms mean. I will also offer evidence from speeches and publications by leading SBC advocates and staff members to demonstrate how school clinics, either openly or covertly counsel and refer for abortions.

[Another term figuring prominently in this discussion is "performing" (or "providing") abortion which means the intentional killing of the unborn child either by dismembering the baby by sharp instruments or by injecting toxic chemicals. At this writing, no school-based clinic performs abortions (Hadley 1986, 34). However, some organizations which sponsor school-based clinics do. For example, the St. Paul-Ramsey Hospital Center in St. Paul, Minnesota, which operated several of the most widely emulated SBCs from 1973 through 1986, performs both first- and second-trimester abortions.]

Defining "Counseling" and "Referral"

Defining terms is an essential first step in this controversial public policy debate, because the SBC advocates will sometimes give an erroneous impression of what services a clinic is performing by twisting the usual meaning of words, especially the terms "counsel" and "refer."

"Counseling" by SBCs means informing the pregnant girl about her "legal options"--abortion or birth--and assisting her in making a decision about what course of action to take. Counseling is usually conducted in conjunction with a laboratory test and a physical examination to confirm pregnancy (U.S. Dept. of Health and Human Services 1981; 3, 10, 12, 13).

One of the key pieces of information provided to a pregnant girl during counseling is the fact that she has the constitutionally protected right to

obtain an abortion without her parents' knowledge or consent. While some states require nominal parental notification or consent, the U.S. Supreme Court has ruled that the girl can bypass her parents by going before a judge (Morrissey 1986, 68-69).

SBC staff members either counsel pregnant girls in their own clinic, or if prohibited from so doing, "refer" the teens to an outside organization who will "counsel" the girl, including telling her that about the "option" of abortion.

"Referral," thus, describes the process of sending the girl to an agency outside of the school to obtain services that the SBC does not provide. (U.S. Dept. of Health and Human Services 1981, 7-8, 13). The staff refers the girls out when the SBC either does not want to provide a certain service itself (such as performing abortions) or is prohibited from providing a service (such as being involved with abortion-related activities).

In addition to "referring" for "counseling," SBCs also refer for abortions--either directly or indirectly. When the rules permit, SBCs will refer pregnant teenaged girls directly to an abortion provider in the community. (Right-to-life advocates usually connect the word "referral" solely with this type of activity since national family-planning industry operates in this way.) This referral might consist of giving the girl the name and location of the abortionist, directions to the office, the hours of operation, and information about possible sources of funding for the abortion, such as Medicaid or loans.

An example of this appeared in a story in the New York Times on October 15, 1986. It explained how Fran Combe, the resident nurse practitioner in the clinic located in Martin Luther King Jr. High School in Manhattan, made seven abortion referrals during one school year (Perlez 1986). According to the Times, five of the ten girls who were found to be pregnant at Combe's clinic had abortions at the Eastern Women's Center, "the abortion clinic at 14 East 60th Street that she most frequently recommends" (emphasis added). Combe also directed two other pregnant girls to another abortion facility. (The remaining three young women gave birth to their babies.)

The second scenario obtains when the SBC staff is prevented by regulations or school policies from offering counseling and direct referrals to abortionists. In this case, they arrange what we will call an "indirect" referral for those abortion-related services. The school clinic circumvents

the restrictions by sending the pregnant girl to an agency outside of the school, which is not governed by the same restrictions, such as the local Planned Parenthood, city or state public health clinic, or public hospital. There she could obtain a confidential pregnancy test, counseling about abortion, and another referral by the community-based agency to an abortionist (an abortion provider). As we shall see, SBC staff have persuaded themselves that this type of indirect referral does not violate school or parental restrictions on abortion-related activities.

SBCs Allowed to Perform Abortion Counseling and Direct Referrals

According to SBC proponents, the laws and regulations governing a school clinic's operations determines what type of arrangements the staff makes to guarantee that pregnant girls can obtain abortions confidentially. I will initially examine two sets of reasons SBCs which perform on-site abortion counseling and direct referrals to abortionists without parental knowledge or consent. This section will also point out the flaws in the SBC proponents' flimsy justifications for their abortion counseling techniques. Then I will turn my attention to how the school-clinic staff utilizes indirect referrals to achieve the same objectives. (There are no published statistics revealing how many SBCs take either approach.)

Federal and State Requirements Said to Mandate Abortion-Related Activities

Some SBCs justify performing controversial abortion-related activities in their own facilities on the grounds that they are obligated to do so by either state or federal law.

For example, the October 1986 issue of Clinic News, published by the Center for Population Options' clinic Support Center, listed thirty-three states and the District of Columbia where minors are empowered to give their own consent to obtain pregnancy tests, counseling, and referrals (Center for Pop. Options 1986, 3). In twelve of those states, the teens can consent for all of their own medical care, including pregnancy testing and abortion.

Some key federal programs also carry similar explicit requirements.

They provide a relatively small amount of the total SBC financial support nationally but have a profound influence all out of proportion to their number for two reasons.

First, receipt of funds from a source such as Title X of the Public Health Service Act imposes requirements on the whole program. This provision is especially important in view of the efforts to pass new federal SBC funding that carries similar stipulations. For example, S. 110 would pour millions of dollars into new SBCs and would require that they perform confidential abortion counseling and referrals.

Likewise, according to an authoritative book by two attorneys and a pediatrician on providing confidential health care to adolescents, a SBC is legally bound to provide teenagers with confidential abortion counseling and referral if it received any funds from Titles XIX ("Title Nineteen," Medical Assistance) and XX ("Title Twenty," Aid to Families With Dependent Children) of the federal Social Security Act (Morrissey 1986, 63). The dollar amount of SBC funding from these two programs in 1986 was also rather small--about 2% of the total SBC funding (Lovick and Wesson 1986, 13). However, the income could increase in the future as more SBCs learn how to tap into these sources.

Federal programs also carry great influence for a second reason. Their operating policies determine national standards. Observed Asta Kenney, Guttmacher Institute staff member, speaking at the annual SBC conference in October 1986, the Title X program sets the standards for the entire "family planning industry," including of course SBCs. She noted that the Title X guidelines require that recipient agencies provide services to minors without parental knowledge or consent (Kenney 1986).

"Non-Directive" or
"Objective" Counseling

SBC proponents assert that when the school clinics counsel pregnant girls about abortion, they employ the so-called "non-directive" methods used by Planned Parenthood and other members of the national family-planning industry funded by Title X. They claim to describe the two possible choices--abortion or birth--without promoting either one (Wattleton 1981, 23; U.S. Dept. of Health and Human Services 1981, 12, 13).

SBCs may even go so far as to state that they do not perform "abortion" counseling per se on the grounds that they present abortion merely as one

"option." For example, the Center for Population Option's School-Based Health Clinics: A Guide to Implementing Programs avoids the word "abortion" by using the innocuous term "pregnancy counseling" which describes informing "pregnant patients" about "all of their legal options" (Hadley 1986, 89 and 34).

During policy debates, SBC advocates commonly make two misleading and inaccurate assertions about their counseling techniques. The first is that counseling can be performed in a neutral manner. The rhetoric of terms such as "non-directive" merely disguises the real agenda. "Counseling abortion would be pointless in the absence of an expectation that some women receiving such counseling will choose to have an abortion," pointed out the federal Department of Health and Human Services in its proposal on September 1, 1987 for new guidelines for counseling by Title X grantees (U.S. Dept. of Health and Human Services 1987, 33211).

Offering counseling about abortion sends the clear message to the students that both the SBC and the school believe that abortion is a morally acceptable and medically safe practice. In other words, abortion counseling in an SBC represents endorsement by the policymakers of abortion as a possible "choice." So-called "objective" counseling by SBCs about abortion is impossible.

The clinic personnel's second deceptive claim is that so-called "ethical" considerations compel them to counsel pregnant teenaged girls about abortion. "SBC practitioners," stated the SBC operating manual published in October 1986 by the Center for Population Options, "adhere to standards of medical ethics which state that pregnant patients are entitled to know all of their legal options [including of course, abortion]" (Hadley 1986, 34). Taking their cue from the family-planning clinics funded by Title X, the staff must provide that information and guidance, they assert, in order for the girls to give "informed consent" (Hayes 1987, 174).

Critics of this policy have pointed out two reasons why this line of argument falls apart under scrutiny. First, the proponents seriously misrepresent and subvert the traditions of the healing profession. Medical ethics places no burden on physicians and other health-care professionals to support or perform abortion--in fact, just the opposite. By embracing abortion, the SBC advocates have forsaken the traditional "sanctity of life" ethic in Western Civilization, which has encouraged doctors and nurses to protect the health and welfare of all members of the human race, both born

and unborn (Wardle and Wood 1982, 141-156; U.S. Congress. Senate 1982, 46).

Second, the events of the last fifteen years has completely destroyed the credibility of the clinic proponents' alleged interest in promoting "informed consent." Their litigation in federal and state courts has prevented enforcement of state and local laws requiring that a pregnant girl be given accurate and comprehensive information about the status of her pregnancy, the nature of the abortion procedure, and possible short- and long-term complications (Wardle and Wood 1982, 91-103; Horan, Grant, and Cunningham 1987, Appendix One).

The evidence clearly reveals that the clinic proponents' assertions about being compelled by "medical ethics" to promote abortion is a thinly veiled disguise to justify their pro-abortion ideological and political agenda.

Despite these flaws in the rationalizations justifying counseling, a review of press reports of debates about SBCs discloses that school-clinic advocates have been quite successful in using their misleading rhetoric to defuse criticism. Most of the media and public attention has focused on abortion referrals, possibly because counseling a pregnant teenager may not appear to have as direct a cause-and-effect relationship with abortion as giving her directions to the nearest abortionist.

One final point that is extremely important in connection with the requirements of state and federal law is the selective effect of the laws on SBC policies. Local elected officials and parents may not be aware that the laws would permit enforcement of parental consent regulations for some services in the school-based clinic (such as athletic physicals) but not for others (such as abortion counseling). In other words, the local authorities may erroneously believe that their parental consent policies control all of the clinic's activities when they actually control only part of them. The authoritative manual, School-Based Health Clinics: A Guide for Implementing Programs, published by the Center for Population Options, explained that "[l]aws in most states guarantee confidential family planning services to teenagers, but a different set of consent rules applies for general medical treatment" (Hadley 1986, 48). "At SBCs, staff members urge students to talk with their parents about sexual matters," states the manual, "but clinics respect the law insofar as informing parents directly about these matters" (Hadley 1986, 32).

SBC proponents may refrain from pointing out when the law conflicts

with policies approved by the school board, and one wonders how many parents are informed about the potential conflicts when their school board or city council is considering opening school clinics.

Counseling and Referrals Done When Regulations Do Not Prohibit Them

A second category of clinics which provide on-site abortion counseling to pregnant teenaged girls, pointed out Asta Kenney at the SBC conference in Denver, are those which--in the absence of local or state laws or school regulations to the contrary--adopt the same policies as the Title X-funded facilities. She explained that the staff assumes that the same rules of "confidentiality" that govern family planning clinics operated outside the school, also apply to SBCs within the schools (Kenney 1986).

This approach should not be surprising since much of the impetus for starting SBCs came from the family-planning industry, including Planned Parenthood and other Title X grantees. They are urging the SBCs to adopt the policies that they have employed for the last two decades in their facilities in the community.

According to Kenney, federal programs which provide most of the government funding, such as the federal Maternal and Child Health (MCH) block grant (Title V of the Public Health Service Act), do not have specific stipulations either requiring or prohibiting parental involvement (Kenney 1986). According to a report compiled by the Center for Population Options during 1986, the MCH block grant provided twenty-seven percent of the funding for SBCs (Lovick and Wesson 1986, 13).

Using Indirect Referrals to Circumvent Restrictions On Counseling and Direct Referrals

When confronted with school regulations or parental prohibitions which prevent them from providing on-site pregnancy tests, abortion counseling, or direct referrals to abortionists, SBCs utilize two strategies to circumvent the restrictions to show pregnant teens how to obtain those forbidden services elsewhere.

One method is to employ the informal channels of communication within

the school to inform the students where to go for pregnancy tests and abortion counseling. Speaking at a conference in San Diego in November 1986, Kathleen Arnold-Sheeran, a long-time nursing and administrative staff member of the St. Paul clinics and currently director of the National Association of School-Based Clinics, explained that the clinic staff in the St. Paul program was careful to inform students that the clinic did not offer abortion counseling because of the terms of a special federal grant from the Adolescent Family Life program under Title XX ("Title Twenty") (quoted in Patton 1986). However, at the same time, the staff ensured that the girls knew the location of another facility nearby where they could obtain a free confidential pregnancy test and abortion referral. "We certainly talk to kids and let them know there are options available," she stated. "We just can't go into any details talking about abortions."

The result, pointed out the former SBC staffer, is that the pregnant girls who are considering abortion "don't come to us for their pregnancy tests." They went to the outside agency. This arrangement not only allowed the clinic to maintain a facade of not promoting abortion, but it also created the impression that the clinic was actually quite successful in convincing teens to give birth. Since the pregnant girls contemplating abortions avoided the SBC, almost all of the girls who received positive pregnancy tests at the clinic carried their babies to term. According to Arnold-Sheeran because "[n]inety-eight percent that [sic] come in for pregnancy tests continue their pregnancy" (quoted in Patton 1986).

In circumstances where the SBC performs abortion counseling but is prevented from referring girls directly to an abortion provider, the clinic staff uses a different plan. They direct the pregnant teens to an agency outside of the school, such the local family planning or public health agency, which itself <u>does not</u> perform abortions. Then the outside agency, which is not covered by the school's or parents' restrictions, arranges to send the girls to another agency or facility, which <u>does</u> perform abortions.

This clever policy, while somewhat round-about, effectively accomplishes the objective. Moreover, it gives the SBC staff the semantic "out" they need because they can claim that they did not "refer" the girls to an abortion facility. Somehow the SBC staff believes that sending pregnant girls <u>indirectly</u>, rather than <u>directly</u>, to the abortionist, sufficiently changes the nature of the activity that they are off of the hook.

The director of public policy for the Center for Population Options, Jodie Levin-Epstein, explained how this duplicitous method operates in practice during her speech at the workshop at the Denver SBC meeting titled "Parents: Consent and Confidentiality" (Levin-Epstein 1986). "In practice, it is our understanding," she said, "that where a parent has not given consent for participation in a program, or in those instances [where] there is a checkoff for a particular program and the student for whatever reason isn't supposed to be served by that [SBC] program according to the parental consent [form], the program refers for [that] service, or handles it in whatever way has been articulated by the advisory board" (emphasis added).

Commenting on that policy at the same workshop, Cleve Holt, a nurse practitioner with the Orr High School Clinic in Chicago, said "We do not even mention abortion in the school-based clinic. If it does come up, we refer them out. We don't talk about it" (Holt 1986).

Steve Purser, health planning coordinator in charge of the Balboa High School clinic in San Francisco, gave a more extensive explanation of how this indirect abortion-referral policy operates during a workshop on March 6, 1986 at the annual meeting of the National Family Planning and Reproductive Health Association. His remarks are worth quoting at length.

Although his clinic is heavily supported by federal Title X money, which would normally require abortion referrals without parental knowledge or consent, he will not do that because "we don't want to usurp the parents' role" (Purser 1986). "The last thing you want to do," emphasized Purser, "to have a parent sign a consent from saying I want to exclude 'x' service, then provide that service to the child." Then he went on to reveal that the actual reason for obstensibly being so respectful of the parent's wishes was pure politics. If the clinic gave unauthorized services, "[t]he school board would shut us down--literally," he stated emphatically.

Turning next to the issue of referrals, Purser asked himself the question of "What do we do if they [students] come to us and the parent says 'I don't want my child to receive family planning'?" (Purser 1986) If that situation arises (or if there is no signed consent form at all), he explained that "[t]hey are referred to a clinic that's about a mile-and-a-half from us, which is another health department clinic that provides family planning services." When the teenager is referred to the outside clinic, Purser stated, they "are no longer a student receiving health care at the high school, [instead] they become part of the [general] health systems

population." Since the nearby city-operated health facility is not under the same restrictions as the school clinic, students receive medical treatment without parental knowledge or consent.

This point about the use of indirect abortion referrals should be emphasized because it is so important. If the SBC is prohibited from sending a pregnant girl directly to an abortionist, then clinic personnel can and will circumvent the parents' wishes simply by sending her to an agency or organization outside the school which itself does not perform abortions but which will refer the girl to someone which does perform abortions. Technically, of course, the SBC has not referred the girl directly for abortion.

Once a clinic opens in a school, this method for procuring abortions indirectly by utilizing referrals to outside agencies would be very difficult to identify and regulate. Moreover, if a controversy does develop over referrals, the clinic staff could raise new justifications for their actions, such as claiming that medical ethics or the students' "right to privacy" under federal, state or local laws. The best solution is to not open a school-based clinic in the first place.

Pro-Abortion "Sex Education"

In addition to referring pregnant girls for abortions both directly and indirectly, SBCs also promote abortion through their in-school education programs. The pilot programs in St. Paul and Baltimore, which have been widely emulated throughout the country, strongly emphasized the value of clinic personnel working closely with the school's health educators to develop the "reproductive health curriculum," and even to teach classes in order to establish rapport with the students (Ahartz 1986, 90; Zabin et al. 1986, 120, 125; Zabin et al. 1984, 425; Kapp 1986, 83).

This arrangement presents an extraordinary opportunity for the clinic staff to imbue the teens with pro-abortion concepts (usually described as presenting "all of the options") and to explain about the availability of pregnancy tests, of nearby abortion facilities, and of government funds to pay for abortions.

Douglas Kirby, the Center for Population Option's director of research, observed that the classroom presentations "not only serve an educational function, but a recruiting function as well" (emphasis added; Kirby 1985,

13). SBC expert Joy Dryfoos explained that the "[c]linic staff often conduct sex education and family life [education] classes in the school, so they have ample opportunity to encourage the student in the classroom to attend the clinic" (Dryfoos 1985, 73).

Finally, Kathleen Arnold-Sheeran, an experienced clinic nurse and administrator for thirteen years at the St. Paul clinic, stressed the importance of giving "lectures in the classes" at a workshop in San Diego in November 1986. "If you have a SBC without health education services, forget it," she emphasized. "It's no good" (quoted in Patton 1986).

SBCs Pushing Abortion Pills?

Another abortion-related issue that to date has not played a role in debates over SBCs but could be very important in the future is worth mentioning here.

The potential for distributing the abortion pill to teenagers through school clinics was not lost on SBC proponents. In a story appearing in the Boston Globe on December 22, 1986, the chairman of Planned Parenthood Federation's Board of Directors, Dr. Allan Rosenfield, endorsed approval of RU 486 as a "major step forward for teenagers" (Franklin 1986, 1 and 14). He believed, reported the Globe, that if teenaged girls who suspected they were pregnant "knew they could come to a clinic for a pill when their period is late, they would probably show up a lot earlier than they do now." Jonathan Brant, Boston attorney specializing in health care issue, explained to the Globe that "[m]ost current restrictions, such as parental notification laws, would be unenforceable."

Clearly, clinics located inside of schools would be in an especially advantageous position to distribute abortion pills.

Attempts to Minimize Controversy

In order to minimize controversy, SBC advocates carefully "finesse" the abortion connection, to use Joy Dryfoos' apt description. SBC proponents employ several techniques to downplay this abortion linkage and hide their real agenda.

One approach for deflecting criticism is to deny direct involvement--which can be true--yet accomplish the same goal by referring indirectly. Another technique is to orchestrate the pro-SBC publicity and lobbying campaign under the guise of apparently disinterested and objective research.

The SBC advocates' third approach is to claim that the primary objective in promoting SBCs is not to further their own narrow pro-abortion agenda but to provide "comprehensive" medical services. However, SBC proponent Sharon Lovick has revealed how this is a smokescreen for their real objective--"doing something about adolescent pregnancy" (Lovick 1987). In fact, operating clinics inside schools offers Planned Parenthood and its allies an unparalleled opportunity to accomplish four long-sought-after goals: use the close proximity to the students and the school's authority to control the teenagers' lives, counter pro-life gains among the youth, add new sources of income, and diversify their range of medical services.

Section Two:
SBCs' Misleading Claims About Reducing Pregnancies

The right-to-lifers' second objection is to the misleading--and often completely erroneous--claims that SBCs reduce the number of teen pregnancies. A thorough review of their own statistics reveals how the hype does not square with the reality. Data from pilot clinics in St. Paul, Baltimore, and Chicago are simply inadequate to support the any claims of success. SBCs may have been shown to reduce births, but that was achieved by <u>increasing</u> the number of abortions, not <u>decreasing</u> the number of pregnancies.

The exceedingly immodest claims about the "success" in the Baltimore clinic program (Zabin 1986) are particularly important because that pilot program is frequently cited by school-based clinic proponents. In brief, five flaws in project design and interpretation in the Baltimore study stand out.

First, the research team failed to adjust for the student transfers and dropouts during the time between the administration of the questionnaires. Second, the researchers' failure to give numbers, rather than percentages or percent changes, in their published report prevents an independent assessment of the validity of their claims. Third, the researchers failed to account for a "testing effect" that may affected the outcome of the study

when they administered the questionnaire twice at the control school but four times at the experimental school. Fourth, the researcher's failure to list the demographic characteristics of the students surveyed prevents independent analysts from assessing the relative influence on pregnancy rates of important factors, such as marital status, academic achievement, and family traits. And fifth, the research team's failure to account for both the differing pregnancy rates between the sets of schools prior to the beginning of the study, and the fact that the experimental school had a "magnet" program for gifted students.

A spokesman for the leading organization promoting SBCs admitted in a speech in March 1988 that a preliminary study of clinics across the country revealed that they had have "no measurable impact" on teen pregnancy rates. Douglas Kirby, director of research for the Center for Population Options, candidly unveiled the results of a study by his organization in a March 2, 1988 workshop speech at the annual meeting of the National Family Planning and Reproductive Health Association (Kirby 1988). Although he prefaced his comments during the speech in the "Effectiveness of School-Based Clinics" with the caveat that they had not "finalized" the results, Kirby stated that "I am reasonably confident that what I am going to say will hold true" when the final report is published in late summer or early fall, 1988. Since the reduction of teen pregnancies is one of the primary goals of Title X, and there is no proof that SBC programs that do not achieve that goal, SBC should not be funded by Title X.

Kirby's assessment was repeated for the first time in print in an article by Joy Dryfoos, a leading clinic proponent. It was titled "School-Based Health Clinics: Three Years of Experience" and can be found in July/August 1988 issue of Family Planning Perspectives, a periodical published by the Alan Guttmacher Institute, Planned Parenthood's research arm. "Three years ago," wrote Dryfoos, "no conclusions about the efficacy of school-based clinics programs as pregnancy prevention interventions could be drawn because of the lack of reliable impact evaluation data. Unfortunately, the situation has changed little since then," she continued, "mainly because evaluating the impact of school-based clinics on changes in reproductive health behavior presents difficult methodological problems" (Dryfoos 1988, 196).

Unable to show success in lowering the incidence of teen pregnancy, Dryfoos used a tactic commonly employed by SBC proponents of substituting

other measures of success. She discussed how the facilities modified other teen behaviors, such as clinic attendance rates or acceptance by the students. But, of course, neither of these measurements is anything more than marginally related to the principal justification for opening most of the SBCs in the first place--reducing the number of teen pregnancies.

Section Three:
SBCs Undercut Parents

Finally, a third pro-life critique of school-based clinics gas been the SBC staffs' blatant usurpation of parental prerogatives--providing medical care, including abortion counseling and referrals, behind parents' backs, and keeping student records confidential. A comprehensive manual on "School-Based Health Clinics: Legal Issues" published jointly on November 1, 1988 by the Center for Population Options and the National Center for Youth Law, illustrates how SBCs can undermine parental rights (English 1988).

This manual provides detailed instructions on how to structure the SBC program, policies, and organization to minimize meaningful parental oversight. The general approach in the manual could probably be best summarized by one of the authors, Abigail English, quoted in Dryfoos' article on SBCs: "Parental involvement should not be mandated, legislated or coerced because doing so creates unacceptable barriers to necessary and beneficial health care" (Dryfoos 1988, 198).

Section Four
Five Other Objections

In addition to these three key criticisms, opponents have raised other major objections, financial and moral, to clinics. Their financial considerations include questions about the high cost/low cost-effectiveness of the clinics; the inevitable requirement for government funding; and the need for extensive medical liability insurance coverage should cause policymakers to reject SBCs. In addition, many parents and other concerned citizens are justifiably worried that the clinics will overburden school systems which are barely able to achieve their fundamental educational mission now. And finally, critics have pointed out the racist implications of targeting the clinics almost exclusively for schools in inner-city

minority neighborhoods.

PROMOTING RESEARCH ON ABORTION-CAUSING DRUGS AND DEVICES

During the past seven years, a French drug manufacturer, Roussel-Uclaf, assisted by researchers in the United States and at least ten other countries, has employed RU 486 in experiments on thousands of women to induce abortion by blocking the action of an essential hormone, progesterone (Kolata 1988). The anti-progesterone, whose name is derived from the company's initials (RU), disturbs the delicate hormonal balance of pregnancy, and is much more complex and subtle than surgical abortion, which involves cutting up and scraping the baby out of the womb.

The National Right to Life Committee objects to the provision of S. 110 which authorizes a new source of funding for "to promote the development... and bringinng to the marketplace" of new so-called "contraceptives," because the bill fails to define the term "contraceptive." NRLC has no position on contraception, properly so called. But in the absence of clarifying language, the bill could promote the development and marketing of drugs which in fact substitutes for surgical abortion, such as the RU 486 abortion pill.

RU 486 is used in France to induce abortions between four and eight weeks. Yet many of its proponents attempt to obscure its abortion-inducing nature, referring to as a contraceptive, "contragestive," or other such misleading labels. Some gullible journalists have fallen for such disinformation, and have referred to RU 486 as a "morning-after pill" which "dislodges the fertilized egg."

In fact, RU 486 is used in France only well after a woman knows she is pregnant-- between four and eight weeks. In other words, the earliest that the drug is administered is well after the embryo has implanted in the uterus. While some research was done attempting to employ RU 486 as an anti-implantation drug, it did not prove suitable for such application. Since late 1986 RU 486 supporters concentrated on perfecting techniques for using the abortion pill after a woman misses her menstrual period and knows she is pregnant (Murphy 1986, 64; Kolata 1988, A1; Steinbrook 1988)

The obvious purpose of the language in Section 7 of S. 110 is to permit

the federal government to help bring RU 486 to the American market. Promoters of the drug are frustrated that they have been unable to secure from pharmaceutical companies in the United States, which have refused to either test or market the pill for two reasons (Kolata 1988, A1; Family Practice News 1987; Gapen 1987). The companies' executive recognize how vulnerable they would be to liability lawsuits from selling such a dangerous drug, and the officials also foresee a backlash from a national boycott from the right-to-life movement and its millions of supporters.

Proponents of RU 486, such as the leading researcher Dr. E.E. Baulieu from France, and Dr. C. Wayne Bardin from the Population Council in the U.S., recognize that they face an uphill battle to win approval from the U.S. Food and Drug Administration to market the drug because of safety and liability considerations. (Rosenfield 1986, C1; CBS Morning News 1986).

Shift of Emphasis in 1986

Media interest in RU 486 came in two distinct waves in 1986. In the spring, the New Republic magazine ran an influential article by Tony Kaye titled "Are You For RU-486" (Kaye 1986, 14). Like most stories in early 1986, Kaye failed to clearly explain that RU 486 was not a contraceptive but an abortifacient. The second wave came in December, sparked by a special session at a conference sponsored by the strongly pro-abortion "Catholics for a Free Choice" and an article and editorial in the influential New England Journal of Medicine (Couzinet, et al. 1986, 1565; Hansen 1986, 7) Interestingly, by December most accounts correctly described RU 486's abortifacient properties.

To most people, "conception" is synonymous with "fertilization," the unique moment of union of sperm and egg. (For example, Stedman's Medical Dictionary [1982, 308] and Blakiston's Gould Medical Dictionary [1984, 305]). In this sense, a "contraceptive" would prevent "fertilization." (National Right to Life takes no position on contraception.)

However, the proponents of RU 486 are using "contraceptive" as it was redefined in the late 1960s by the American College of Obstetricians and Gynecologists (ACOG) (Hughes, 299). ACOG threw out the traditional meaning and made "conception" synonymous with "implantation," the time about six days after fertilization when the developing human embeds itself in the

lining of the mother's uterus.

By ACOG's re-definition, RU 486 does adt as a "contraceptive" when it acts to prevent implantation. But even under ACOG's current definition, RU 486 remains an abortifacient, because it is being administered at four to eight weeks-- well after implantation.

The researchers themselves may inadvertently have helped establish the reputation of RU 486 as an abortifacient by selecting an abortion experiment to publicize their "product" in December 1986. Much of the press attention surrounding RU 486 centered around the lead article in the December 18th issue of prestigious **New England Journal of Medicine** which described using RU 486 to induce abortions in women who were four to five weeks pregnant (Couzinet 1986, 1565).

In searching for opposing viewpoints about the new drug, the press usually failed to note the growing criticism from two groups within the pro-abortion ranks questioning the safety and morality of the drug. First, as researchers conduct more clinical trials during the next few years on RU 486, we are likely to hear more from feminists and health care professionals voicing their concerns about how the drug affects women's health. Despite a strong pro-abortion bias, these groups maintain a healthy skepticism toward any new "birth control" method in view of the past callousness demonstrated toward women by drug companies and organizations such as the Rockefeller Foundation and the Population Council, which are actively promoting RU 486 (Boston Women's Health Collective 1980, viii-ix; Network News, 1984, 5; Corea 1985, 3; Ehrenreich et al. 1979, 31).

Significant Safety Hazards from RU 486

Much like the ill-fated Dalkon Shield, the abortion pill RU 486 is being hyped as a "safe" method of birth control, and the print and electronic media has repeated claims by the abortion pill's promoters without scrutinizing them adequately. Of course, this powerful abortion pill is lethal for unborn babies, but it also has extremely hazardous short- and long-term side effects for pregnant women who take it. Tests during the past seven years have revealed several important immediate side effects, including severe nausea, mild uterine pain, vomiting, weakness, and fatigue (Spitz and Bardin 1985, 260-262; Baulieu 1985, 1 and 19). Despite reports of no evidence of damage to the hormonal system from taking the drug, the

long-term effects of repeated use of RU 486 will not be known for years.

Every pregnant woman who takes RU 486 has heavy bleeding, which would be especially dangerous to women in the Third World. Researchers reported in the British medical journal Lancet that half of the women who took RU 486 bled 12 days or more, and some bled for six weeks (Rodger and Baird 1987, 1416). Most of them had twice the amount of bleeding of a normal menstrual period, and some had six times as much.

Moreover, if a woman with an ectopic pregnancy (in the fallopian tube) takes RU 486, the bleeding will give her a false impression that she is no longer pregnant; however, the eventual rupture of her fallopian tube would endanger her life (Herrmann 1985, 187).

Many prospective patients would probably not be thrilled to learn that drug is not very effective in what it is designed to do--cause abortions, and the researchers acknowledge that they do not know why (Baulieu 1985, 16-17).

Moreover, when the abortion pill does not produce a complete abortion (between 5 and 15% of the time), the woman must have immediate surgery to stop the bleeding and repair the damage (Rodger and Baird 1987, 1417-1418). Also since the drug has been tested for less than five years, the first generation of RU 486 users will be guinea pigs to determine the pill's long-term effects on women's health and fertility. Researchers have recognized that if RU 486 does not work, there is some likelihood that the mother would deliver a handicapped child if the pregnancy were carried to term.

On September 23, 1988, the Reuters news service indirectly quoted Professor Jean-Michel Alexandre, president of the government's Medical Sales Commission that reviewed the abortion pill. Alexandre explained at a news conference that the "main drawback to the new drug was that it could cause malformations to a baby that survives, and all women who take it would be virtually obliged to have another abortion if the pregnancy was not terminated the first time" (Hayden 1988).

The possibility of damage to the child was confirmed by a published report on October 6, 1988 in a British scientific periodical of one baby had been born dead six months after its mother took RU 486 (Nature 1988). Andre Ullman, medical director of Roussel Laboratories in Paris, described this case in a closed medical meeting on January 10, 1989 at the Beclare Hospital in Clamart France.

The possibility also exists that RU 486 could damage the mother's

genetic material, or the genes of her subsequent offspring, because RU 486 has a chemical makeup similar to DES, which caused severe deformities.

To date, no conclusive evidence exists that RU 486 is anything more than a killer drug. Advocates of RU 486 have exaggerated the fragmentary results from a mere handful of tests about possible therapeutic uses of the drug.

Other Reservations About an Abortion Pill

The media's projection that the American public would welcome an abortion pill is based on an inaccurate and one-sided reading of public opinion polls about abortion. The majority of Americans are opposed to legal abortion except for a very narrow set of "hard cases," such as rape, incest, and endangerment of the life of the mother. Most Americans definitely do not support the current situation, where no more than 1% of abortions are done for these so-called "hard-case" circumstances. Marketing RU 486 in the United States would heighten--not decrease--the public's uneasiness about abortion because the pill further trivializes the decision to take innocent human life.

Moreover, opinion polls reveal that Americans oppose marketing the abortion pill in the United States. For example, a Gallup poll conducted for a health industry publication and released January 23, 1989 showed that 62 percent of the one thousand adults polled replied "no" to the question: "Should U.S. drug companies produce drugs for the sole purpose of causing abortions?" (Leberto 1988, 1).

In view of strong opposition from the right-to-life movement and publicity about these ethical and safety drawbacks being raised even in some pro-abortion quarters, proponents of RU 486 such as Dr. Baulieu remain cautious about projecting when RU 486 might be marketed in the United States as a pill to cause very early abortions. However, the "major barrier to introduction of any birth-planning method," Dr. Bardin stated on CBS Morning News, remains "how much money is it going to make?" (CBS Morning News 1986). Drug companies are unwilling to shoulder the potential liability costs of costly litigation if someone is hurt by the drug.

National Right to Life's opposition to RU 486 arises out of a concern to protect both the life of the unborn child and the life and health of her

mother. American women aren't looking for a "chemical Dalkon Shield." Neither are we.

CONCLUSION

S. 110 would authorize and promote the use of Title X funds in school-based clinics, and under the Title X guidelines, these clinics would be required to provide confidential abortion counseling and referrals. The National Right to Life Committee opposes the introduction of abortion services in this nation's high schools. The National Right to Life Committee will oppose any effort to involve the federal government in school-based health clinics unless the abortion-related problems are resolved in the authorizing legislation.

NRLC will also oppose any effort to authorize or appropriate federal funding for research and development of abortion pills.

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Senator ADAMS. Ms. Gaston?

Ms. GASTON. Mr. Chairman, Senator Kassebaum, I am honored to be invited to testify here today on Title XX. I will summarize my testimony as briefly as possible.

I represent the National Organization on Adolescent Pregnancy and Parenting. NOAPP is a private nonprofit organization of individuals, organizations, foundations, and businesses throughout the United States helping to work to prevent teen pregnancy and to help teen parents become healthy, productive contributors to family and community life.

The president of NOAPP is Mary Ann Liebert, of Seattle, who sends her greetings in support of this legislation.

Senator ADAMS. Thank you very much.

Ms. GASTON. I am appending to my testimony an impressive list of national organizations that support Title XX. Before explaining why NOAPP and so many other State and national organizations support this bill, I would like to briefly describe the program that I operate in Albuquerque.

New Futures School is a comprehensive, single-site care program for pregnant adolescents and adolescent parents. We provide care services to 500 adolescents per year, child care services to the children of these teen parents, and primary prevention services in the form of peer education to over 2,000 non pregnant adolescents annually.

New Futures School is an example of the kind of networking this legislation will achieve in communities throughout the United States. We are sponsored by the public school system and a community-based nonprofit corporation.

Support for our services comes from businesses such as U.S. West, BDM, and the Marriott Hotel, civic organizations such as Civitan Clubs and Executive Women's International, local and national foundations, State agency grants, and employee group donations from local businesses.

The University of New Mexico School of Medicine, the Public Health Department, and several licensed adoption agencies provide services on site in addition to the services provided directly by New Futures School. We provide all of the core services described in the legislation and all of the listed supplemental services. Teens, including previous dropouts—and I think it's important to note that many people believe that 25 to 30 percent of pregnant adolescents were dropouts before they became pregnant—any of these teens may work toward a high school diploma or prepare for the GED with us.

Independent follow-up studies have documented key outcomes which demonstrate the cost effectiveness of New Futures School in terms of lower low-birth weight rates, higher percent of graduation from high school, lower repeat pregnancy rates, and lowered welfare dependency.

Mr. Chairman, we know that programs like this can achieve results. We know that early and regular prenatal care and good nutrition can reduce the incidence of health problems that adolescents are more likely to have, such as prematurity, low birth weight, and infant mortality.

We know that leading voices in the business community are becoming increasingly concerned about the school dropout rate and its negative effects upon our Nation's ability to be competitive in today's global market. Teen pregnancy is one of the leading causes of school dropouts.

The 1989 Ohio Education 2000 Commission opens its report in this way—and this is an education commission:

> To have the best chance of success, every child needs to be born at full term and full weight of a mother who has had proper prenatal health care and nutrition and who is drug and alcohol free, to be nourished and nurtured during infancy and to receive the kind of mental stimulation teaching and encouragement during early childhood needed to prepare formal education.

Programs supported by this Title XX legislation will do just that for thousands of children of teen parents throughout the United States who would otherwise be unlikely to begin life with such a good start. We know that teen parents are very likely to have repeat pregnancies. Programs funded by this legislation should reduce repeat pregnancies, as we have at New Futures.

In this statement I have chosen to focus on the effectiveness of services to teens who are already pregnant or parents because that is the main thrust of Title XX. The pregnancy prevention and research components of this bill are also extremely important. However, since other Federal programs address those concerns, we believe the priority in this particular legislation needs to be on services to pregnant and parenting teens and their families.

There is no other Federal program whose only purpose is to provide services related to teen pregnancy. While teenagers do in fact constitute some of the case load in many programs, they are likely to fall through the cracks. S. 120 is set up as a safety net to catch these youngsters, and it is sorely needed.

This program is the glue that will hold together and maximize local and other resources, and that is why it can do so much with very limited funding amounts.

S. 120 is more than a simple reauthorization of the adolescent and family life demonstration projects. It maintains the basic structure of the current law inasmuch as it sets out to help adolescents prevent pregnancy through educational services targeted to them and their families, to help pregnant teens, young parents, and their families overcome the problems that so often accompany early pregnancy and parenthood and which prove costly to society, and to support research on the causes and consequences of pregnancy in childbearing for adolescents.

We know from experience with the adolescent and family life program and its predecessor legislation that there are a number of program models that work and that merit replication. We have also learned that Federal funding is crucial to the very existence of many highly successful programs.

While building on the past framework, S. 120 also makes some important changes which NOAPP finds are supported by most service providers and potential providers. It recognizes that, after 8 years, the time for demonstration projects is past. We know that certain key services work and programs that provide these services urgently need ongoing financial support. This bill contains strong provisions on parental involvement that strike a fair balance be-

tween the needs of adolescents for services and the desirability that parents be involved in the provision of services.

All grantees are required to encourage parent and family involvement, but services are not to be denied to young people who decide not to consult their parents or who are unable to do so.

S. 120 ensures that pregnant adolescents will be informed of the availability of counseling on all options regarding the pregnancy so that they can make a decision appropriate to their own situation and values with the help of those persons closest to them.

The new bill also strengthens the accountability and evaluation provisions in the current law.

Mr. Chairman, Senator Kassebaum, this is a good, cost-effective bill that holds out hope for thousands of disadvantaged youngsters of two generations, the teen mother and her child. It is a pro-life, pro-family bill in the best sense of the term, helping young women and their families and their children through pregnancy and the early stages of parenthood in situations where there is often little hope.

And it is a bill that is good for society because it can help reduce adverse pregnancy outcomes and the often lifelong consequences of health problems at birth, dropping out of school, poverty, and welfare dependency. And therefore, it will help save taxpayer dollars. Thank you.

[The prepared statement of Ms. Gaston with attachment follows:]

PREPARED STATEMENT OF CAROLINE GASTON

Mr. Chairman and Members of the Committee:

I am honored to be invited to testify here today on the Adolescent Pregnancy Prevention, Care, and Research Grants (S.120). I represent the National Organization on Adolescent Pregnancy and Parenting (NOAPP). NOAPP is a private, non-profit organization of individuals, organizations, foundations and businesses from throughout the United States working to help teenagers prevent unintended pregnancy and, in the case of already-pregnant teens and young parents, become healthy, productive contributors to family and community life. The President of NOAPP is Mary Ann Liebert of Seattle, Washington, who sends her greetings and support of this legislation. I serve on the Board of Directors of NOAPP and am also Principal/Program Director of New Futures School in Albuquerque, New Mexico. In recent months, NOAPP has worked closely with many national organizations on S.120, and I am appending to my testimony a list of national organizations that support the measure. Before explaining why NOAPP and so many other state and national organizations believe the Adolescent Pregnancy Prevention, Care, and Research Grants Act is needed, I would like to describe briefly the program I operate.

New Futures School is a comprehensive single-site care program for pregnant adolescents and adolescent parents in Albuquerque, New Mexico. We provide care services to 450-500 adolescents per year, child care services to 250 children of these teen parents each year, and primary prevention services in the form of peer education to over 2,000 non-pregnant adolescents annually.

New Futures School is an example of the kind of networking this legislation will achieve in communities throughout the United States. We are sponsored by the public school system and a community-based non-profit

corporation. Support for our services comes from businesses such as US WEST, BDM and the Marriott Hotel, civic organizations such as Civitan Clubs and Executive Women's International, local and national foundations, state agency grants and employee group donations from local businesses. The University of New Mexico School of Medicine, the Public Health Department and several licensed adoption agencies provide services on-site in addition to the services provided directly by New Futures School staff.

Services provided by New Futures School include all of the core services described in this legislation and all of the listed supplemental services such as child care, counseling and employability training and counseling. Students who are in school when they become pregnant may transfer to New Futures School if they wish to do so. New Futures School offers all of the courses required for high school graduation, a number of vocationally-oriented courses, and courses in perinatal health, child development and parenting. Teens who have dropped out of school (many people estimate that 20-30% of pregnant adolescents are dropouts before the pregnancy) may re-enter school through New Futures School and work toward a high school diploma or prepare for the GED equivalency diploma.

Independent follow-up studies have documented key outcomes which demonstrate the cost-effectiveness of New Futures School. Low birthweight rates are only 6%; the most recent follow-up study found that 73% of former NFS students had graduated from high school and 4% were still in school. 54% of the graduates had gone on to post-secondary education. Only 16% of former students were on welfare. Repeat pregnancy rates are 6-11% at one year postpartum. We believe that children of our students are healthier and better prepared to become successful in school themselves in a few short years. In

short, New Futures School makes a positive difference for the economic health of our community, for families and for children.

Mr. Chairman, we know that programs like this can achieve results:

- We know that early and regular prenatal care and good nutrition can reduce the incidence of health problems that adolescents are disproportionately likely to experience, such as prematurity, low birthweight and infant mortality. It used to be thought that adolescents are simply too immature physically to have babies, but it has become clear that, for most teens, pregnancy and childbirth are no more risky physically than for women in their prime childbearing years -- if they get proper prenatal care and improved nutrition. This does not hold true, however, for the very youngest teens. Neither does it mean that teen childbearing is desirable. Participation in the WIC supplemental feeding program has been shown to be associated with improved pregnancy outcomes, especially improvement in birthweight.
- Programs that make pregnancy testing easily accessible, free or at very low cost, have been shown to help get young women into early prenatal care. Without such services teens tend to delay receiving prenatal care.
- Studies show that only 50-60% of adolescent women who become mothers ever complete high school and this, in turn, has implications for the young women's employability and ability to be self-supporting. Leading voices in the business community are becoming increasingly concerned about the school dropout rate and its negative effects upon our nation's ability to be competitive in today's global market. Teen pregnancy is one of the leading causes of school dropout. This bill, through its required core service of referral to appropriate education and its requirement that referrals be followed up, should reduce the dropout rate for the communities which receive

these funds. Evidence from programs from San Francisco and Baltimore to Florida, as well as New Futures School, indicates that alternative school programs for pregnant and parenting adolescents increase graduation rates.

- Given the importance of completing high school before entering the job market, many programs with an employment orientation emphasize the development of "employability" skills — i.e. the acquisition of a basic education, some job skills and the motivation to work — rather than actual job placement services. A major evaluation of such projects showed that participants gained significantly more work experience than a control group, scored higher on employability tests and demonstrated motivation to work. The National Alliance for Business and the U.S. Department of Labor recognized New Futures School, which uses this approach, as a model program in their joint Youth 2000 publication, "Count Me In, Youth 2000."
- 60-70% of teen parents experience a repeat pregnancy within two years. We know that the provision of family planning services can increase birth control use and continuation. Nevertheless, efforts to prevent a repeat pregnancy are not always successful, and we need to learn more about effective strategies to provide family planning education and contraceptive care to young mothers. We suspect that it is important to help them understand the benefits of avoiding a second pregnancy. This is the approach we use at New Futures School, and our repeat pregnancy rates are only 6-11% at one year postpartum.

The 1989 Ohio Education 2000 Commission, which was chaired by Procter and Gamble Chairman (Ret.) Owen B. Butler, opens its report by stating that:

"To have the best chance of success, every child needs:

- To be born at full term and full weight of a mother who has had proper prenatal health care and nutrition and who is drug and alcohol free;

- To be nourished and nurtured during infancy and to receive the kind of mental stimulation, teaching and encouragement during early childhood needed to prepare for a formal education."

In this statement, I have chosen to focus on the effectiveness of services to teens who are already pregnant or who are parents, because that is the main thrust of S.120. The pregnancy prevention and research components of this bill are also extremely important. However, since other federal programs address those concerns, we believe the priority in this particular legislation needs to be on services to pregnant and parenting teens and their families. There can and should be a close interrelationship between care and prevention services. Many care programs for adolescent parents provide peer education to non-pregnant teens focusing on why, from a teen's perspective, it is not a good idea to become a teen parent. Program providers will welcome research that can enhance and target program services more effectively.

The proven services mentioned above -- prenatal care, pregnancy testing, education and employment-related services and family planning -- are some of the core services that S.120 is built around which benefit mother and baby. We know, therefore, that this legislation presents a winning strategy. And, lest there is some concern that these services are already being provided through other federal programs, let me assure you that this legislation does not duplicate other programs. There is no other federal program whose only purpose is to provide services related to teen pregnancy. While teenagers do, in fact, constitute some of the caseload in many programs, they are also notoriously likely to fall through the cracks. S.120 is set up as a safety net to catch these youngsters. Grantees will ensure that a high risk population that is too young to negotiate its own way through the web of

current services will receive the care it needs. It will help them find appropriate educational opportunities, and get time off school for prenatal care visits. If prenatal care is lacking in a community, a grantee can pay for that; if nutrition services are inadequate, those services can be supported. In short, this program is the glue that will hold things together. And that is why it can do so much with very limited resources.

S.120 is more than a simple reauthorization of the Adolescent Family Life Demonstration Projects. It maintains the basic structure of the current law, inasmuch as it sets out to (1) help adolescents prevent unintended pregnancy through educational services targeted to them and their families; (2) help pregnant teens, young parents and their families overcome the difficulties that so often accompany early pregnancy and parenthood and which prove costly to society; and (3) support research on the causes and consequences of pregnancy, childbearing and child rearing for adolescents.

We know from experience with the Adolescent Family Life program and its predecessor legislation that there a number of program models that work well and that merit replication, with some modifications. We also have learned that federal funding is crucial to the very existence of some highly successful programs. While building on the past framework, then, S.120 also makes some important changes which NOAPP finds are supported by most service providers and potential providers.

- It recognizes that, after eight years, the time for demonstration projects is past. We know that certain key services work, and programs that provide these services urgently need ongoing financial support. The need for services is great: over a million adolescents a year become pregnant and close to half a million carry the pregnancy to term. Without the core services provided by

this legislation, too many of these young women and their children will become costs to society for years to come rather than contributors to our economy. As the Committee for Economic Development, an organization of CEOs and Fortune 500 companies and University presidents, has stated so clearly, it is essential that we make the necessary investments in our children which will result in a strengthened national economy in the future. Projects supported by this legislation will be such investment.

• The bill contains strong provisions on parental involvement that strike a fair balance between the needs of adolescents for services and the desire of many parents to be involved in the provision of services. All grantees are required to encourage "parent and family involvement in each of the core services," but services are not to be denied to young people who decide not to consult their parents or who are unable to do so. This language recognizes that adolescents can often benefit from the advice of their parents but that when parent-teen communication or support is lacking, the teen's best interests and those of the baby are paramount. To withhold prenatal care, for example, pending parental consent or notification would be counterproductive, simply causing many young people to postpone the initiation of care, harming both the teen and the baby. One of the tasks of adolescence is to learn to make independent decisions and take responsibility for one's own life in preparation for adulthood. A teen mother must learn that she is responsible for the life of her child as well. This bill helps adolescents in that crucial task.

• On a related matter, the bill also recognizes that adolescents need to determine the course of their own lives in a matter as fundamental as having a baby, with the assistance of full information to help in the decision-making

process. S.120 ensures that pregnant adolescents will be informed of the availability of counseling on all options regarding the pregnancy, so that they can make a decision appropriate to their own situation and values, with the help of those persons closest to them.

• The new bill strengthens the accountability provisions in the current law to avoid a recurrence of the unfortunate situation where data on the impact of the current program are too frequently unavailable in a usable form./ Grantees will be expected to earmark 3-10 percent of their grant funds for evaluation to be conducted by an independent evaluator. They will also be required to report the characteristics of their client populations, the services provided, data on prenatal care and pregnancy outcome, educational attainment and economic status. And they will have to provide comparison data to indicate the program's impact. The Secretary of DHHS will also be required to conduct evaluations and to submit to Congress a summary of his evaluations and those conducted at the local level. We believe this sort of strict accountability is crucial when public dollars are being spent.

Mr. Chairman, this is a good, cost-effective bill that holds out hope for thousands of disadvantaged youngsters of two generations -- the teen mother and her child. It is a pro-life, pro-family bill in the best sense of the term, helping young women, their families and their children through pregnancy, childbirth and the early stages of parenthood in situations where there is often little hope. And it is a bill that is good for society because it can help reduce adverse pregnancy outcomes and the often life-long consequences of health problems at birth, dropping out of school, poverty and welfare dependency, and therefore will save taxpayer dollars.

More and more business leaders across the United States are saying, "No

more prizes for predicting floods — only prizes for building arks." I have described the flood of problems which are occurring to children to two generations resulting from adolescent pregnancy. This legislation will enable many communities to build an ark by putting together the total package of things that work to bring disadvantaged children back into the mainstream of America — to give them an opportunity to prosper economically, intellectually, and spiritually. This is the kind of ark that we need to build for today and tomorrow.

ORGANIZATIONS THAT SUPPORT S.120

ACORN
American Association for Counseling and Development
American Association of University Women
American College of Nurse-Midwives
American College of Obstetricians and Gynecologists
American Home Economics Association
American Jewish Congress
American Mental Health Counselors Association
American Nurses Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American School Counselors Association
Association of Junior Leagues
Center for Population Options
Child Welfare League of America
Children's Defense Fund
Concerned United Birthparents
General Federation of Women's Clubs
Girls Clubs of America
National Association of Counties
National Council of Jewish Women
National Education Association
National Family Planning and Reproductive Health Association
National Organization on Adolescent Pregnancy and Parenting
National Women's Political Caucus
Nurses Association of the American College of Obstetricians and Gynecologists
Planned Parenthood Federation of America
The Alan Guttmacher Institute
U.S. Conference of Mayors
Women's Equity Action League
YWCA of the U.S.A., National Board

New Futures School - Annual Report
1987-88

TOTAL NUMBER OF CLIENTS SERVED	PERINATAL	YPC	TOTAL
In classes this year (Note: 25 students first enrolled in the Perinatal Program and moved to YPC at mid-term. In the following data these students are reported under the Perinatal Program.)	349	113	462
New students enrolled this year			391
South Valley Outreach Program			93

SERVICES TO NON-ENROLLED ADOLESCENTS	TOTAL
Individual personal counseling and health counseling	221
Outreach groups (Schools, churches, youth groups, etc.)	2180
Young fathers	363

SERVICES TO ADULTS	TOTAL
Outreach groups	1977
Services to family members	929
In-building visitors	162

DEMOGRAPHIC DATA ON REGULARLY ENROLLED CLIENTS

	PERINATAL	YPC	TOTAL
ETHNIC BACKGROUND			
Anglo	98 (28%)	24 (21%)	122 (27%)
Black	24 (7%)	5 (5%)	29 (6%)
Hispanic	202 (58%)	69 (61%)	241 (59%)
Native American	23 (6.5%)	15 (13%)	38 (8%)
Other (Southeast Asian)	2 (.5%)	0	2
AGE			
12	2	0	2
13	11	0	11
14	23	4	27
15	76	15	91
16	106	28	9
17	82	43	125
18	33	12	45
19	11	8	19
20	4	2	6
21	0	1	1
22	1	0	1
MARITAL STATUS			
Married	32 (9%)	16 (14%)	48 (10%)
Single	316	92	408
Separated	1	3	4
Divorced	0	2	2
RESIDENCE			
Albuquerque	331	102	433
Other N.M. Localities	18	11	29 (4%)

EDUCATIONAL DATA ON REGULARLY ENROLLED CLIENTS

	PERINATAL	YPC	TOTAL
GRADE IN SCHOOL			
6th	3	0	3
7th	8	0	8
8th	18	5	23
9th	90	24	114
10th	90	27	117
11th	69	30	99
12th	71	27	98
SCHOOL ATTENDED BEFORE NEW FUTURES			
Albuquerque High School	34	8	42
Cibola High School	9	6	15
Del Norte High School	18	6	24
Eldorado High School	5	2	7
Highland High School	43	10	53
La Cueva High School	6	0	6
Manzano High School	31	4	35
Rio Grande High School	26	10	36
Sandia High School	10	4	14
Valley High School	17	5	22
West Mesa High School	30	8	38
Other High Schools in Albuquerque	18	3	21
Middle Schools	34	16	50
Other New Mexico Schools	44	18	62
Out-of-State Schools	23	12	35
Elementary School	1	0	1
PREVIOUS SCHOOL DROP-OUT (Out of school at least 4 weeks)	113 (33%)	52 (46%)	165 (36%)

50 Students completed their high school graduation requirements while enrolled in NFS. An additional 19 students completed their secondary education with a GED during the school year.

	PERINATAL	YPC	TOTAL
REASON FOR LEAVING PROGRAM			
Pre-delivery			
Remain at home	43		
GED	11		
Return to regular school	16		
Graduated	6		
Work	2		
Unknown	4		
Moved	14		
Death	1		
Post-partum			
Remain at home	50	32	
Work	6	8	
GED	17	22	
School	35	15	
Graduated	22	19	
Moved	13	7	
Unknown	2	3	

REFERRALS TO OTHER AGENCIES

- 60 - DHS/AFDC
- 23 - DHS/Protective Services
- 43 - DHS/Food Stamps
- 4 - Chaparral Adoption Services
- 138 - Albuquerque Technical-Vocational Institute
- 8 - Shelter for Victims of Domestic Violence
- 50 - Marie Amadea Shelter
- 42 - Low-cost Housing
- 2 - LULAC (Help with post-secondary financial aid applications)
- 1 - Parentcraft
- 10 - Triad Adoption
- 1 - Parents Anonymous
- 1 - Tribal Council
- 1 - Job Corps
- 1 - Programs for Children
- 1 - Gas Co. Low Income Program
- 1 - St. Vincent de Paul
- 4 - Families for Children
- 1 - Barret House (housing)
- 2 - Legal Services
- 1 - Store house
- 2 - Substance Abuse/Care Unit
- 1 - Substance Abuse/Charter
- 1 - Operation Identity
- 1 - Catholic Social Services
- 2 - Family Institute
- 5 - Rainbow House Adoption Agency
- 2 - Mediation Services
- 1 - Indian Legal Services
- 2 - Family & Children's Services

HEALTH STATISTICS ON REGULARLY ENROLLED CLIENTS

	TOTAL	
Deliveries	158	
Maternal Complications		
Anemia	3	
Kidney Problems	6	
Premature Labor	10	
Premature rupture of membranes (PROM)	1	
Induced labor	11	
Infection	6	
Hemorrhage	6	
Epidural anesthesia	41	
Forceps	12	
Toxemia	17	(1/w hemorrhage)
Cesarian section - failure to progress	3	
CPD	4	
Abruptio placenta	1	
Fetal distress	5	
Breech	3	
Failed induction	0	
Reason not known	1	(w/toxemia & pp infection)
Miscarriages	4	
Breastfeeding at hospital discharge	70	(44%)
Infant Complications		
Meconium staining	1	
Meconium aspiration	5	
Respiratory distress	5	
Low birth weight	9	(5.7%)
Premature	10	
Infant mortality	0	
Jaundice requiring phototherapy	6	
Fetal death	2	

HEALTH STAFF ACTIVITIES

Home visits this quarter	130
Hospital/Dr. visits this quarter	11
Number seen in Immunization Clinics	126
Number seen in WIC Clinics	608
Number seen in Family Practice Clinics	248
Number seen in Evening Childbirth Classes	492

	PERINATAL	YPC	TOTAL
Number of student illnesses handled	144	67	211
Number of children's illnesses handled	112	359	471

COUNSELING SPECIAL ACTIVITIES

Counseling staff	TOTAL
Home visits this quarter	61
Hospital visits this quarter	21
Releases for adoption	11 (7%)

Counseling Special Activities:

Ed Sedillo continued to serve as a Board member of the Marie Amadea Shelter.
Ed Sedillo and Emma Loud attended several training sessions on working with victims of child abuse and sexual abuse.
Counselors conducted weekly counseling groups in Personal and Child Health, Special Education, Care and Raising of Toddlers, and Middle School Block classes.
Counselors conducted a 2-week unit on Understanding Yourself in each Personal & Child Health class.
Counselor Julie Sisneros co-facilitated SCASA (Students Concerned With Substance Abuse), a counseling group.
Counselor Joy Shain spoke to a group of students' parents during our Open House.
Counselors identified students with needs for Christmas food boxes.
Ed Sedillo took workshops in "Suicide and Satanism" and "Incest".
Joy Shain facilitated a weekly Alternatives counseling group for students considering releasing for adoption. On occasion, counseling groups included parents of group members.
In the summer of 1988 Lee Protomastro did a followup study to 1986-87 NFS students.
All counselors took a 2 day intensive training in working with victims of domestic violence. One day was led by Lenore Walker, and the second day by Natalie Porter, Ph.D., Director of Programs for Children.
One counselor was on duty one day a week during the summer, at a nearby health clinic, to talk with students and do intakes for new students.

South Valley Outreach Activities

NFS nurse Chris Griego worked 1 1/2 days each week doing outreach services with non-NFS teen parents in the economically-deprived South Valley. She conducted a weekly parenting education group for teen parents enrolled in School on Wheels, another APS alternative school.
Approximately 93 different clients were served individually during the year.
Through Outreach efforts, 15 out-of-school teen parents made the decision to enroll in New Futures School.

Volunteer Activities

Volunteer activities were coordinated by a volunteer, Betsy Saxton.
Volunteer Carolyn Thalman coordinated Dime Time, a thrift shop for students, with the help of several volunteers.
3 four-hour orientation/training sessions were conducted by Betsy Saxton for new volunteers.
3 newsletters were distributed to volunteers.
The volunteer year began with an Open House for volunteers in September and closed with a Volunteer Appreciation reception in May.
There were approximately 25 active volunteers during the year.
Twice-monthly Dime Times were held during the lunch hour. In addition, counselors and nurses could take needy students to Dime Time at any time. RE-NEW, a special section of Dime Time which specialized in career clothing, helped Jobs Program students to get job-appropriate clothing. Dime Time volunteers also held a Christmas Bazaar, in which students could purchase inexpensive Christmas gifts.
4 Foster Grandparent volunteers helped in our Day Care Centers and with tutoring individual students.
A Tupperware Party raised over $200 for Day Care playground equipment for our new building.
Volunteers helped to prepare caps and gowns for graduation, tutored individual students, made new aprons for the Day Care Centers, participated in Albuquerque's "Volunteer to Make a Child Smile" volunteer awareness fair, and assisted with RIF distributions.

Community Information Efforts

To adolescents:

NFS staff, often assisted by students or our videotape "See What the Future Will Bring", made presentations aimed toward the reduction of teen pregnancy to 2180 adolescents, in settings which included classes in all APS High Schools; 6 APS middle schools; 2 APS alternative schools; Los Lunas High School; Menaul School (private school); Pecos High School; Socorro middle schools; Bernalillo High School; St. Mary's School in Belen (private), and one elementary school.

To adults:

NFS staff, New Futures, Inc. Board President Anne Nokes, APS Board member Pauline Martinez and panels of NFS students made presentations on adolescent pregnancy issues to 1,977 adults in settings which included a New Mexico legislative interim committee, church groups in the Lutheran and Methodist churches, a Birthright volunteers training session, NFS volunteers training sessions, a number of University of New Mexico classes, civic clubs, a meeting of the Council of Great City Schools, a U.S. Department of Education staff meeting, APS teacher in-service training sessions, Leadership Albuquerque, staff of cooperating agencies in Albuquerque, the National Commission to Prevent Infant Mortality, the National Federation of Democratic Women, a Task Force to improve education in Ohio, and community meetings in Socorro, NM and Hopkinsville, KY. We were also aware that Owen B. Butler, Chairman of the Committee on Economic Development's Task Force which wrote "Children in Need: Investment Strategies for the Educationally Disadvantaged" made many speeches throughout the United States which included references to New Futures School as a model program.

Through conferences:

NFS staff, Caroline Gaston, Linda Barr, Sharon Fox, Toni Berg, Mary Sullivan, Gina Sullivan, Joy Shain made presentations to conferences as described below:

Wingspread conference of the National Center on Effective Secondary Schools - Gaston, Sullivan, on aspects of New Futures School.
National Forum on At-Risk Youth. Gaston, on New Futures School. model program for at-risk youth. Washington, DC.
National Organization on Adolescent Pregnancy & Parenting annual conference. Gaston, on Administrative Issues in teen pregnancy services. San Francisco.
Maintaining Active Parent Partnerships conference. Gaston, on aspects of a comprehensive program for teen parents, Indianapolis.
Home Economics State Supervsiors annual conference. Fox, on the NFS Jobs Program, G. Sisneros, on Teaching Parenting to Teen Parents, Gaston, on the positive effects of services. A conference general session featured the NFS videotape "See What the Future Will Bring." San Francisco.
New Mexico Organization On Adolescent Parenting and Pregnancy annual conference. Berg on Teaching Breastfeeding to Teen Parents, Shain on Family Therapy for teen parents, Fox, on the NFS Jobs Program. Albuquerque.

Phi Delta Kappa Reluctant Learners conference. Gaston, on working with dropouts and potential dropouts. Albuquerque.
New Mexico State Department of Education conference on At-Risk Youth. Gaston, on aspects of New Futures School. Albuquerque.
UNM/NM Nurse Practitioners conference on Current Comments on Primary Health Care. Gaston, on "Why Don't They Follow Our Health Care Instructions". Albuquerque.

Media:

The March 15, 1988 New York Times carried a front page story, with picture, on New Futures School. The story was syndicated and ran in several other papers throughout the United States.
Caroline Gaston was interviewed by long distance phone for a live NYC radio program.
"Education Week" carried a full page story on New Futures School.
Japanese TV Asahi filmed for 3 days at NFS and ran a 7 minute piece on Japanese television news.
NFS staff and/or students were interviewed on local TV channels 4, 7, 13 and KKOB and KUNM radio at various times during the year. The 3 major TV stations all ran pieces on the New Futures School Groundbreaking.
Caroline Gaston was interviewed by telephone and NFS provided a picture for Sonnthesdlick, a Swiss Sunday news supplement.
Descriptions of New Futures School appeared in "A Compendium of What Works for Vocational Educators in Dropout Prevention", a publication of the National Center for Research in Vocational Education, and "Women in Poverty - Training for Independence, 2nd edition, a publication of the National Alliance for Business.
CBS-TV Evening News carried a segment on NFS on Labor Day.
NFS is described as a model program in "Children In Need : Investment Strategies for the Economically Disadvantaged", a publication of the national Committee for Economic Development.
The Greater Albuquerque Medical Association newsletter ran an article on teenage pregnancy co-authored by Linda Barr.
The Albuquerque Tribune ran 2 articles on NFS during the year.
Julie Sisneros was interviewed, in Spanish, for a National Public Radio program, and also for local station KRZA.
An NFS student and her child were flown to New York City to appear on the Donohue Show's program on teen pregnancy.
"Count Me In - Youth 2,000", a publication of the U.S. Departments of Health & Human Services and Labor and the National Alliance for Business decribes NFS as a model program to help youth fulfill their potential.
The NOAPP Network carried a story on the NFS Jobs Program and ran a reprint of the 1987 valedictory speech of an NFS graduate.
Many Home Economics journals and newsletters ran stories on the selection of Sharon Fox as Home Economics Teacher of the Year for the U.S.
"Challenges to Urban Education: Results in the Making" a publication of the Council of Great City Schools, included a description of NFS as a model program.

In-Building Visits

Groups from Lubbock, TX, Boise, Idaho, Modesto, CA and Sioux Falls, SD made indepth visits to NFS as a part of their efforts to upgrade their services to adolescent parents.

162 individuals or small groups from a number of agencies and communities throughout Albuquerque and New Mexico, and from cities as far away as San Francisco, Indianapolis, St. Louis and New York City made visits to New Futures School. State Representative Bill Camp, U.S. Senator Jeff Bingaman, a member of the U.S. Senate Budget Committee, Owen B. Butler, Ret. Chairman of Proctor and Gamble, the National President of the Jewish War Veterans Auxiliary, and County Commissioner Jacquelyn Shaffer were included among the visitors.

School Special Events

Special all-school events were held monthly. This year these included a trip to the State Fair exhibits in September; holiday parties at Halloween, Christmas, Valentine's Day, and Easter; a Substance Abuse Awareness Week; Career Week; Adoption Awareness Week; and an end-of-year field trip to the zoo.

Science, Middle School Block, Special Education, and Children's Literature classes took field trips to sites of course-related interest such as the Indian Pueblo Cultural Center, Jemez Pueblo Feast Day, Maxwell Museum, a hospital's Health Careers Day, a children's book store, and the Museum of Natural History.

The City Bookmobile provided library services every other week.

UNM presented a financial aid workshop for interested students.

An Open House was held for parents of students, in connection with Thanksgiving Dinner.

Students formed a Student Council, which planned and carried out several projects.

Seniors planned, raised money for, and implemented their Graduation Ceremony and Reception. The last Graduation Ceremony in the Monroe facility was held May 27.

The American History class did special activities for Black Awareness Week.

3 Reading Is Fundamental (RIF) distributions were held during the year.

American Literature students planned and carried out Mark Twain on the Rio Grande Day, complete with jumping frogs and a freckle contest.

Students and staff took field trips to the new school facility.

The Director of the State's Child Support Enforcement Bureau made several excellent presentations to students.

The Annual Awards Assembly was held in May.

Other Activities

Caroline Gaston
- served as a mentor for the Leadership Albuquerque Education Committee.
- served on the March of Dimes Health Promotion Advisory Committee.
- continued to serve as a Volunteer Consultant to the Board of the National Organization on Adolescent Pregnancy and Parenting (NOAPP).
- served on the City Human Services Planning Committee.
- was appointed to the Governor's Task Force on Adolescent Pregnancy.
- completed her second term on the state title X Advisory Committee.
- provided consultation services to Socorro, NM; Hopkinsville, KY.
- attended a meeting of the Committee for Economic Development, to whom she served as an advisor last year.
- served on the KOB-TV For Kids Sake advisory committee.

Linda Barr
- served on the state Committee on Adolescent Health Promotion.
- served on the Executive Board of the Adolescent Pregnancy Prevention Task Force.
- served on the KOB-TV For Kids Sake advisory committee.
- served on the Greater Albuquerque Coalition for Children Board.
- served on the New Mexico Organization on Adolescent Pregnancy and Parenting Board.
- served on the March of Dimes Health Promotion Advisory Committee.
- chaired a meeting of the Albuquerque Technical-Vocational Institute Health Occupations Advisory Committee.
- chaired the Leadership Roundtable for NOAPP's annual conference.
- provided consultant services to Crownpoint, NM.
- served on the Governor's Health Professional Advisory Committee.
- was appointed Chair of the Governor's Task Force on Adolescent Pregnancy.

Nancy Davis, nurse/health educator, was appointed to the state Title X Advisory Committee, replacing Caroline Gaston.

Sharon Fox, Jobs Teacher
- served on the Western New Mexico University Home Economics Advisory Committee.
- served on the state Board of Education's Ad Hoc Committee on Student Achievement, which was focusing on At-Risk Youth.
- was honored, as National Home Economics Teacher of the Year, by the State Board of Education, the Albuquerque Board of Education, and in the Congressional Record of August 4, 1987.

Math teacher Mary Schwartz received an Outstanding Achievement Award from U.S. West, and was honored by the APS Board of Education for this distinction.

New teachers this year were Marcy Martinez (Math), Ginger Johnson, who returned to NFS as teacher of Childrens Literature and Home Tutor, Nancy McGovern (U.S. History, Literature), and former NFS substitute Becky Siglar (1/2 time Home Tutor). Gloria Lee moved from Child Development Aide to Secretary.

Anne Nokes was President of New Futures, Inc. until May, when Mike Allen was elected as President.

Plans for the new building for New Futures School were completed. The bids came in within budget, and a Groundbreaking Ceremony was held November 11, 1987. NFS students and staff and many former staff and long-time supporters attended. Big Bird children assisted with the ceremony. Speakers included the APS Board President; the New Futures, Inc. Board President; Linda Barr, who helped to found New Futures School, and a student spokeswoman.

NAACOG accepted a curriculum co-authored by Linda Barr on Perspectives on Adolescent Sexuality, as a part of its continuing education curriculum.

New Futures School was a Reading Is Fundamental participant for the first time this year.

A very active Vocational Advisory Committee, composed of private and public sector members, advised the Jobs Program.

A multi-ethnic Advisory Committee helped with the development of our Children's Literature curriculum.

All staff had a half-day training on AIDS, and a half-day training from Stephen Glenn, Ph.D. on "What's Happened to Teenagers". Several teachers took Effective Teacher Training. NFS nurse Nancy Davis taught CPR to Child Development Aides. 4 staff took Substance Abuse Prevention training. All counselors, the Academic Dept. Head, and a nurse took 2 days of training in working with abuse victims, from Dr. Lenore Walker. Mary Sullivan attended the National Dropout Prevention Conference. Chris Griego attended the Texas state conference on teen pregnancy. Linda Barr led two Family Talks training sessions.

A new videotape was produced. "Teaching Loving Care" depicts the NFS philosophy of incorporating child care and parenting education, with some attention given to the program's general approach to working with teen parents.

Linda Barr was selected as Nurse of the Year by the New Mexico section of NAACOG.

Because NFS could not provide summer school in the summer of 1988 due to its pending move, a cooperative effort between the Job Corps and JTPA was developed to enable teen parents to earn summer credits.

Outside funding came from Mountain Bell ($2,000 for Child Care); the Albuquerque Community Foundation ($3,900 for training for staff of agencies, including NFS, who work with abused teens); the Hasbro Children's Foundation ($19,900 for a new Children's Literature curriculum), the Ford Foundation ($6,000 for the new Home Tutor program); the Levi Strauss Foundation ($25,000 for the Home Tutor program); the State Department of Education Vocational Education Unit ($31,537 for our Jobs Program); the NM Health and Environment Department ($3,500 for technical assistance and prevention programs); the NM Human Services Department ($83,000 for Family Services.)

New Futures School was recognized as a model program during the State Department of Education At-risk Conferences.

NM Governor Carruthers selected an NFS student to represent New Mexico in the Pause for the Pledge in Baltimore on June 14. Sheila Delaney, accompanied by Caroline Gaston, represented New Mexico in the 4-day patriotic event.

ADOLESCENT PREGNANCY - NEW FUTURES SCHOOL

Some Key Facts

* More than half the Aid to Families with Dependent Children (AFDC) budget in the United States goes to women who had their first children in their teen years. With equal education, however, teen mothers are no more likely than their peers to be on welfare. The key factor is that nationally, less than half of school-age mothers graduate from high school. (Kristin Moore, Ph.D. The Urban Institute). In the Albuquerque Public Schools it is estimated that at least 30% of Native Americans, 24% of Hispanics, 23% of Blacks and 16% of Anglos who enter the 9th grade do not finish school.

NEW FUTURES FACTS
- IN RECENT YEARS 41-45% OF NEW FUTURES STUDENTS HAVE BEEN FORMER SCHOOL DROP-OUTS RETURNING TO SCHOOL THROUGH NEW FUTURES.
- A MAJOR FOLLOW-UP STUDY IN 1987 FOUND THAT 77% OF NFS STUDENTS HAD A HIGH SCHOOL DIPLOMA OR WERE STILL IN SCHOOL. 54% OF THE GRADUATES HAD POST-SECONDARY EDUCATION OR TRAINING.
- THE SAME STUDY FOUND THAT ONLY 16% OF THE FORMER STUDENTS WERE RECEIVING AFDC WHEN CONTACTED.
- 97% OF NFS STUDENTS PASSED THE NEW MEXICO HIGH SCHOOL PROFICIENCY EXAM IN 1986-87

* Numerous nationally-reported studies found repeat pregnancy rates of 18-25% at one-year postpartum. Repeat pregnancies lessen a teen's chances of graduating, and increase health risks for mother and baby.

NEW FUTURES FACTS
- NFS FOLLOW-UP STUDIES HAVE FOUND REPEAT PREGNANCY RATES OF 6-11% AT ONE-YEAR POSTPARTUM.

* Most doctors and nutritionists believe that breastfeeding is the most healthy way to feed an infant.

NEW FUTURES FACTS
- IN 1986-87.....50% OF NFS STUDENTS CHOSE TO BREASTFEED THEIR BABIES.

* Teens are more likely to have low birthweight babies. Such babies are more likely to have health and developmental problems. Nationally-reported rates run from 14.5% for 14 year olds to 9.4% for 15-19 year olds. The low birthweight rate for children of women of all ages in Bernalillo County is 7.7%.

NEW FUTURES FACTS
- IN 1986-87.....6% OF BABIES BORN TO NFS STUDENTS WERE LOW BIRTH-WEIGHT. ONE-THIRD OF NFS STUDENTS WERE 15 OR YOUNGER.

NEW FUTURES SCHOOL MAKES A DIFFERENCE - FOR SOCIETY, FOR FAMILIES, FOR CHILDREN

New Futures School
5400 Cutler, NE
Albuquerque, NM 87110
(505) 883-5680

9/88

Key Facts from Five Year Follow-up Study of Pregnant/Parenting Teens Enrolled in New Futures School 1980-81 through 1984-85

An independent researcher conducted a follow-up study in 1987 with a randomly - selected sample of students who attended New Futures School in 1980-85. The following data summarizes the key findings of that study.

EDUCATION

73% had finished high school; 4% were still in school
54% of the graduates has post-secondary training or education

EMPLOYMENT/WELFARE

57% were working - of these 87% had finished high school
33% of those not working had not finished school
26% of those not working were in school
43% of the married women were not working
16% were receiving welfare (AFDC)

MARITAL STATUS

34% were currently married
42% of those ever married have divorced

HEALTH

94% said their child was up to date on shots
9% of their children had been in the hospital over night
6% said they had a handicapped child
90% described their own health as good - 4% said they were "sick a lot", and 5% said their health was "so so"

FAMILY SIZE

Average number of babies these teens have had since NFS attendance - .5
Median birth spacing - 33 months
Repeat Pregnancies at one year Post-Partum (not all carried to term) - 11%
36% reported the repeat pregnancy as "planned"
Methods of birth control - 55% use the Pill. Next highest were IUD and the Diaphragm - 3% each

EMOTIONAL STATUS

80% said they were happy - things going well
17% said things were "so-so"
83% were happy with their decision to keep or release. (1 had released, the others had kept)
22% mentioned that the lack of money was their major problem

EVALUATION OF NFS

93% said that their attendance at NFS had been "extremely useful"

The 2 features most commonly given as useful were parenting & academics

Senator ADAMS. Thank you very much, Ms. Gaston.

Ms. Gaston, I think your program is not only fascinating, but terribly important because it is the bridge program between the prevention programs we have been discussing and the Head Start program and others which we have found is a rescue program.

Can you give me some idea of the costs of this program or the potential for public-private funding? It would seem to me that this would be quite an expensive undertaking. Can you give me any idea of what the—well, let's break it into two parts: When do you first become involved with or aware of the pregnant woman? And second, what is your general cost or the amount that you feel is necessary to bring that person from where you find them until you feel that they can be released into the community?

Ms. GASTON. We would like to be able to come in contact with a pregnant teen as early in her pregnancy as possible. But they have to be self-referred, of course. No one can be forced to come to our program.

Senator ADAMS. They are self-referred.

Ms. GASTON. They are self-referred. Someone in their school, in their church, in their medical care may tell them about us, but the choice is theirs. They may certainly stay in their regular school. So it is up to them to come to us.

Senator ADAMS. You do not charge at all for this service? You use the grants and the private funding?

Ms. GASTON. This is true. We are a part of the public schools, so some of the costs would be the same costs as if they were in regular public education. However, some of the special parenting classes, child development classes, our jobs program, our child care programs, are additional costs. And some of those are borne by a variety of grants then.

I could provide individual financial data, but it is a case of putting it together.

Senator ADAMS. Would you do that?

Ms. GASTON. Yes.

Senator ADAMS. I don't mean that you have to do that orally, but would you do that in written form to the committee so that we have some data on your program so that we can extrapolate that into some national costs and some potential for what this Title XX program both might cost and some of the costs it might save?

Ms. GASTON. Well, we definitely believe that it would save a lot of money. But I can say in general it is about the same cost as special education.

Senator ADAMS. As special education?

Ms. GASTON. Yes.

Senator ADAMS. Thank you.

Senator Kassebaum?

Senator KASSEBAUM. It would seem to me, Ms. Gaston, that your school is offering support services similar to those of the school in Baltimore. Would that be correct?

Ms. GASTON. I believe that is correct, from what I know of the Paquin School.

Senator KASSEBAUM. Well, I am very impressed with the school in Baltimore, and I think that you give eloquent testimony to what can be done with a positive program that brings help.

I would like to ask you about the counseling and the program that you spoke of. If you had been advised to abstain from sexual activity or to seek counseling and consultation with your parents, would that have made any difference in your behavior at that particular point?

Ms. JONES. Well, my mother and father did counsel me about sexuality and how they didn't try to hide it behind big words or different words, give it little names like birds-and-the-bees. They told me how it was, you know. When you—it's sort of like peer pressure, someone can press you into doing something at that time and moment, sometimes you're not going to just say no, you know. And just because everybody else is doing it, you might feel as though you have to do it, you know, to be one of the crowd, "part of the crowd."

Senator KASSEBAUM. But you wouldn't necessarily have changed your behavior? It was a responsibility that you assumed at that point. Then once realizing that you were pregnant, as you said you had the opportunity to have a good support service and were able to have some alternatives that you thought through, is that correct? How did you get referred to the school?

Ms. JONES. I found out through a friend. Her sister had went to the school about three years before I had found out. And she told me that since I was failed in all my classes at the present school that I was at because they didn't have prenatal care, you know, when I went out for clinic appointments, they would be counted as illegal absences.

And when I was coming back to make up for school work, it wasn't offered to me even though I asked for it. And I wanted to be removed from A course to B course where I could keep up, you know, instead of just flunking out, period.

But they refused that. And so I just ended up failing that year.

Senator KASSEBAUM. What would be your advice, if you had to try think of an initiative, part of a program maybe, for your friends. What do you think would be the most useful program in the schools or in the clinics? Is it education?

Ms. JONES. Yes. Human sexuality should be taught in schools. You should have a knowledge of what you're getting yourself into as a teenagers or as a younger adolescent, say, in junior high school or maybe even in elementary school, as in the sixth grade or fifth grade.

Senator KASSEBAUM. Is there anybody else on the panel that wants to make an observation on that? Ms. Gaston?

Ms. GASTON. We believe that one of the effective things that we do is the teen parents from New Futures School go out and do presentations in the regular schools about how really very difficult it is to be a teen parent and how they hadn't really understood that. And they can give some very real-life, graphic demonstrations that hit home to these teenagers that perhaps an adult couldn't do.

So I do think that peer education maybe is a really important part of it, and we also have to realize that there are many teens that feel pretty hopeless about their lives.

Senator KASSEBAUM. How many students do you have in your school now?

Ms. GASTON. We have 300 enrolled right now.

Senator KASSEBAUM. Do you have a waiting list?

Ms. GASTON. Yes, we do.

Senator KASSEBAUM. Can you take more?

Ms. GASTON. No, we cannot. We take any pregnant teen who comes in because a pregnant teen cannot wait. She needs services right then. But for teen mothers who find themselves in the circumstance that she was mentioning and maybe can't be in a regular school, we don't have any more day care capability in our building, and we have day care capability for 100 people, 100 children. We don't have enough capability, so we do have a waiting list.

Senator KASSEBAUM. Dr. Glasow, I would like to ask you about the school-based clinics. One thing I would like to note is that these clinics are totally under the direction of the school boards. If a school board disapproves, there is no school-based clinic. That is totally up to the school board. Having been a former school board member, I know that is at the discretion of the school board.

Dr. GLASOW. That's true. And in some locations

Senator KASSEBAUM. So I don't want blame to be placed on the Federal Government, or anybody else.

Dr. GLASOW. No. It's the funding is offered as a carrot, and the carrot is——

Senator KASSEBAUM. What funding?

Dr. GLASOW. Well, just to give you an example, if S. 110 goes through with this initiative, as we read it, would be analogous to the foundation grants that were handed out in the last three or four years by some of the largest foundations in the United States, the Anne E. Casey Foundation, the Robert Wood Johnson Foundation. And there was a tremendous amount of discussion at the local level, even though—the Sacramento, CA, is a good example—the initiative, the fact that there was millions of dollars available created a tremendous amount of local discussion, and it turned out that the city did not qualify, according for a Robert Wood Johnson grant. But the point was there was money out there, and that created an interest.

Just the fact there was money, that was the only factor. And that is what we are concerned about here because it carries restrictions or it carries certain types of guidelines that are going to require that the clinic do certain things. And there is trade-doffs that all policy makers have to make, and there is a good policy they would say, well, on balance we would rather have the money and not have this and that and the other thing.

Senator KASSEBAUM. I am a strong believer that school-based clinics should still be totally the discretion of the local school board.

Dr. GLASOW. I believe that they will be.

Senator KASSEBAUM. And they will be. And their funding will be school district funding.

Dr. GLASOW. No, if I could differ

Senator KASSEBAUM. Let me just ask you——

Dr. GLASOW. Sure. Sorry.

Senator KASSEBAUM [continuing]. Regarding education and information. If this legislation said that no funding would go to school-based clinics, would you then support the language regarding education and information?

Dr. GLASOW. We could discuss specific language, I suppose. But our objective is to cut off the school-based clinic from the abortion industry.

And there are—we have asked, we have actually proposed specific guidance to school boards and to local right-to-life individuals who have endeavored to, during the discussions that have gone on around the country, in an effort to neutralize the school-based clinic from abortion and say you can't refer for abortion, you can't counsel for abortion, and you can't send a pregnant teenagers to another facility which counsels or refers for abortion. Once that kind of barrier is erected, then we are out of the equation.

Senator KASSEBAUM. Well, as you know, no Title X money goes to any school-based clinics now.

Dr. GLASOW. Correct.

Senator KASSEBAUM. And I think that if this is a concern, we could add clarifying language that school-based clinics may not receive Title X funding. That is very simple. I don't think anybody is advocating Title X funding for school-based clinics.

Dr. GLASOW. Well, one of the——

Senator KASSEBAUM. But I think we all believe that education and information are important.

Dr. GLASOW. Well, it wasn't just our reading of the bill. The National Family Planning and Reproductive Health Association, a couple of years ago when an identical bill was introduced, read this to mean that it could be used for school-based clinics. And we are, because of our concerns over the way that Title X is implemented right now, with abortion counseling and referral, we are saying we don't want it changed through S. 110 to encourage school-based clinics or Title X money going to school-based clinics or going to abortifacient research and development.

And it is fine that it doesn't go there now. We just don't want it to go there in the future.

Senator KASSEBAUM. Well, I don't think that is a worry.

Dr. GLASOW. Good.

Senator KASSEBAUM. I do think it is important to have good education and information. Also, we have just heard from two very positive programs, and I think that we need to address our concerns to those programs that work, and that are constructive and effective. And I am certainly pleased to have examples of two schools that seem to be very positive and constructive in their efforts to address the real tragedies of this problem.

Thank you.

Ms. JONES. May I say something?

Senator KASSEBAUM. Yes.

Ms. JONES. Also we have a pamphlet telling about programs at our school, and if you would like some information about the program at the school, you can see our principal, Dr. Smith, behind us. And we invite you all to come and visit our environment in our school because you will believe it when you see it. You will understand really what the money should be used for when you come to visit our school.

Thank you.

Senator ADAMS. I want you to know, Ms. Jones, that Senator Mikulski, before she left, left us this and said to welcome you and the

members of your school here. And this will become part of the record.

I also will, by unanimous consent, make part of the record the testimony of Eunice Kennedy Shriver and will leave the record open until midnight tonight for additional written statements that can become part of file of the committee.

[The prepared statement of Mrs. Shriver and additional material supplied for the record follows:]

PREPARED STATEMENT OF EUNICE KENNEDY SHRIVER
Executive Vice President
The Joseph P. Kennedy, Jr. Foundation

Mr. Chairman, I would like to thank you and the other distinguished members of the Committee for giving me this opportunity to present some thoughts about the Adolescent Pregnancy Prevention, Care and Research Act of 1989.

Young people today need our help more than ever. Despite the millions of dollars we have spent over the years on family planning clinics, there are still nearly one million adolescents each year who become pregnant. The nearly 500,000 young women who give birth are those who face the greatest problems. They are likely to be poor, and come from broken families. More than half will not finish high school. Their babies are at significant risk for being born prematurely, the strongest single predictor of infant mortality. Those that survive are more likely to experience health and developmental problems as they grow up.

Problems of this magnitude often leave us wondering what to do. In this case, we know what to do. We simply need to do it. Teenagers need help in facing their sexual lives with self respect, knowledge and a sense of personal responsibility. My own experience with the Community of Caring Program, sponsored by the Joseph P. Kennedy, Jr. Foundation in hundreds of sites around the country, reinforces my belief that young people need to learn about caring -- for themselves, their peers, their parents, friends, and teachers. It is in this caring atmosphere that they

learn to understand the importance and value of marriage and family. Thus they are armed with a sense of their own worth, a sense of values, and the self confidence to exercise wisdom and control when making decisions about all aspects of their lives, including their sexual lives.

Community of Caring programs enlist the whole school, the family, and the community in order to support young people in their decision to postpone sexual activity. These programs have been received enthusiastically in over 20 school systems around the country with many more waiting for training to join in this national effort. They are designed in conjunction with school administrators and the community to ensure the involvement of young people and their families, teachers, coaches, support staff, counselors, doctors, social workers and friends. It is in this "community" of caring, that concerned people nurture young persons and respond to them as individuals who have social, intellectual, emotional and spiritual dimensions that need expression and development. Set against a backdrop of ethical and moral values, young people are encouraged to make responsible decisions in all aspects of their lives, including sexual behavior.

If a young woman does become pregnant, Community of Caring Programs teach the young parents how to take care of themselves and their baby. The parents of the teenagers, and the fathers of their babies are part of the process of sharing values and [redacted]

learning trust. Every indication is that these programs are working. Our programs have shown rates of low birthweight that are 50% less than national norms for young mothers. Young women participating in our programs experience 40% fewer second pregnancies at the end of one year, two years, and five years. More mothers remain in school and/or work full or part time than young parents nationally.

The Federal Government has supported programs for more than ten years which, like the Community of Caring, emphasize the need for young people to delay sexual activity until they are able to sustain caring and committed relationships. When young people do become pregnant, a comprehensive core of services are available which include pregnancy testing, health and nutritional services, education about sexuality and family life, maternal and mental health counseling, referral to educational, employment and vocational services.

Since we know what is needed and we know what works, then it is our responsibility, as a matter of national policy, to pursue that course with vigor. I urge you to move quickly to enact the Adolescent Pregnancy Prevention, Care and Research Grants Act of 1989. This is not a new direction. In fact, much of what is contained in this proposed Act can be found in the Titles VI and VII of the Public Health Services Act, the Adolescent Health, Services and Pregnancy Prevention and Care Act of 1978, about which I have also testified.

Title VI emphasized the need for coordinated, integrated and comprehensive community services which assisted in preventing unwanted initial and repeat pregnancies among adolescents. It enabled pregnant adolescents to obtain proper care and offered services which encouraged them to become independent and productive contributors to family and community life. Title VII created the Office of Adolescent Pregnancy which continues to operate as the responsible Program Unit under the Department of Health and Human Services.

The proposed reauthorization continues to support prevention programs designed to reduce the incidence of adolescent pregnancy through preventive education and skill building programs. When unintended pregnancy does occur, pregnancy testing programs-shown to help young women seek early prenatal care, will continue to be available. Receiving early and regular prenatal care will lead to better birth outcomes for young pregnant women. This proposed bill continues to include services for the young mother which will help her become a better parent, stay in school, and improve the likelihood that she will ultimately become independent and, at the appropriate time, form a stable, committed family.

The proposed amendments to the current Adolescent Family Life Act are in accordance with the original Title VI program. The importance of family and parental involvement was recognized and encouraged, as it is in the proposed reauthorization and

amendments.

The proposed bill encourages the type of flexibility which allows states and local communities to design programs that best reflect local needs and values. The need for extensive community and school involvement, and the success in allowing a variety of program models to develop, is evident in the 68 existing service and 15 research projects which are housed in various community and school settings around the country.

Perhaps most important, the proposed reauthorization recognizes that a successful program should be rewarded with continuing fiscal support. It underscores what I said at the beginning of this statement -- if we know what works, we should continue to do it. And this new bill will not only allow us to continue to do what works, it will allow us to do it for many more adolescents because of the substantial increase in authorized funds.

Over the last ten years, appropriation levels for Title VI, and subsequently Title XX, have been substantially below the authorization levels. It is time we build on all we have learned, and express our commitment to addressing this serious social problem and ensuring a better future for our young people by investing our resources where we know they will make a difference.

To make sure that we do get the most for our investment, and that we continue to learn from our experiences, the proposed

reauthorization significantly strengthens the research and evaluation component as compared to the current legislation. By conducting better evaluations, and conducting research which studies the societal causes and consequences of pregnancy and childbearing among adolescents, we will achieve even greater success.

Our public policy has been taking us in the right direction. Starting with Titles VI and VII, and -- more recently -- the Adolescent Life Program, we have come a long way. The proposed Adolescent Pregnancy Prevention, Care, and Research Grants Act of 1989 builds upon that success. Our young people are our most precious resource. They desperately need our continued caring and commitment. I ask that you express your compassion and your support for our adolescents by acting favorably on this important legislation. Thank you.

20-101 O - 90 - 7

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May 11, 1989

Honorable Edward M. Kennedy
United States Senate
Washington, DC 20510

Dear Senator Kennedy:

On behalf of the American Academy of Pediatrics, whose 37,000 members are dedicated to the promotion of maternal, child and adolescent health, I want to convey to you formally our strong support of the Family Planning Amendments of 1989 (S.110) and the Adolescent Pregnancy Prevention, Care and Research Grants Act of 1989 (S.120). Pediatricians are convinced that these promising complementary legislative proposals, which were addressed in detail at the May 9 hearing before the Senate Labor and Human Resources Committee, would dramatically assist ongoing efforts to prevent unintended pregnancies, and provide important new support to help pregnant teens and young parents.

FAMILY PLANNING AMENDMENTS OF 1989

As contemplated by S.110, there is an urgent need today to reauthorize title X of the Public Health Service Act, the primary purpose of which is the provision of contraceptive services and information to help reduce the incidence of unintended pregnancy, to improve maternal health and to reduce abortion. Since the enactment of title X in 1970, a nationwide system of more than 4500 local clinics has provided nearly 5 million low-income women--including 1.5 million adolescents--with access to comprehensive family planning, basic health screening, and preventive health services and information. In addition to contraceptive services, title X also funds infertility diagnosis, and either treatment or referral for anemia, hypertension, cervical and breast cancer, sexually transmitted diseases, kidney dysfunction and diabetes.

The family planning clinic network also has been recognized as a valuable resource in addressing other closely related health problems such as this country's distressing infant mortality and teen pregnancy rates, and most recently the AIDS epidemic. The Academy has testified consistently before Congress that a strong family planning program directly affects access to prenatal care, low birthweight babies, the infant mortality rate, children who are born with disabilities, children who are neglected, and children who incur catastrophic health care costs.

Unfortunately, title X received precious little support during the Reagan era. In 1981, appropriations for the program were cut from $166 million to less than $125 million. The current appropriation for basic services--$135.1 million--is fully $30 million below the 1981 level, far worse of course if adjusted for inflation. Clinics have been closed; services curtailed; special projects discontinued. The $163 million authorized for basic services in the pending legislation is hardly optimal, but overdue and much needed.

The Academy fully supports, for example, two new initiatives described in S.110 which would improve the provision of basic contraceptive care, namely, encouraging the development of community-based educational programs aimed primarily at teenagers and parents, and a special initiative on contraceptive research and development.

ADOLESCENT PREGNANCY PREVENTION, CARE AND RESEARCH GRANTS ACT

The Academy firmly supports the intent of S.120 to replace the eight-year-old Adolescent Family Life demonstration projects with an ongoing program designed to prevent unintended pregnancy and to help pregnant teens and young parents. This innovative legislation, the authorized funding for which amounts to a modest yet meaningful $60 million annually, would help prevent unintended teen pregnancies through education about sexuality and family life, and through counseling and referral for family planning services.

It would help pregnant teens, young parents and their families through the provision of a broad range of support services, including prenatal and postnatal care; nutrition information; parenting education; referral for treatment of sexually transmitted diseases; educational, employment and vocational services; and pediatric care for the infant. It also would support research on the societal causes and consequences of pregnancy, child bearing and child rearing for adolescents. Grantees, under this new legislation, would be required to encourage adolescents to consult with their parents about services, but receipt of such services would not be contingent on parental consent or notification.

The Academy believes that in tandem these important measures, S.110 and S.120, promise brighter futures for our nation's infants, children and adolescents. Pediatricians are thus prepared to provide any assistance you require to support their passage, and applaud your continuing leadership on these important issues.

Sincerely,

Donald W. Schiff, M.D.

Donald W. Schiff, M.D.
President

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TESTIMONY TO THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE

SUBMITTED BY
JAMES B. O'HORA, EXECUTIVE DIRECTOR
PLANNED PARENTHOOD OF BROOME AND CHENANGO CO., INC.
MAY 11, 1989

Planned Parenthood of Broome and Chenango Co., Inc. is a voluntary non-profit agency, established in 1940 to provide family planning medical, educational and counseling services to all those in need. We see over 6000 patients per year at our urban and rural sites in Binghamton, Norwich, Johnson City, Greene, Windsor, and Sherburne. In addition to contraceptive care, our patients receive screenings for breast and cervical cancer, high blood pressure, anemia, diabetes, pelvic infections, and STD's such as gonorrhea and chlamydia. If desired, patients at PPBCC may also receive voluntary confidential HIV testing, PMS counseling, pregnancy testing with professional options counseling, and Level I infertility services.

All our services are provided on a sliding fee scale, and no one is ever turned away because of inability to pay. For many of our patients, their appointment at PPBCC is their only non-emergency medical visit of the year: No other local providers will see medically indigent patients at reduced rates, and few are accepting new Medicaid clientele.

We strongly believe that the preventive medical and educational services that we are able to provide as a Title X grantee have greatly improved the health of women and children in our community; and teen pregnancy prevention has been one of the cornerstones of our program since the mid-1970's, a reflection of local and national family planning priorities. The benefits of the Title X focus on this population-at-risk are well documented, as is its cost-effectiveness. Not as well publicized are the grateful thanks from women who have used Title X services over the years; we hear them every day, especially when the program's funding has been threatened.

Planned Parenthood of Broome and Chenango Counties, Inc.
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FOR CHENANGO COUNTY · Chenango County Office Building · Norwich, New York 13815 (607) 334-6378

Currently, 49% of our patients are nineteen and under, offering us a critical opportunity to make a positive impact on their future health and well-being. Over sixty percent of these adolescents enter the clinic in the company of a parent or with parental permission. For many others, the counseling they receive at the time of their appointment triggers a future discussion with parents about sexuality issues; for others, Planned Parenthood is their only source of information and counseling about "family life" issues.

We do <u>not</u> take this responsibility lightly. Our adolescent patients are given an extra, teen-only educational session covering reproductive biological information, the serious responsibilities inherent in being sexually active, and ways to approach parents in dialogue. For two years running, PPBCC has been awarded National Priorities funds from Title X for our "Family Involvement Promotional Program", which seeks to urge parents to become the primary sex educators of their children. We have also received high praise in our community for our Mother/Daughter Weekend Retreat Programs, held in conjunction with local churches and civic clubs; the goal of the retreats is to make a bridge of communication between mothers and pre-adolescents on self-esteem, peer pressure, and other pre-sexuality issues.

While we always encourage <u>parental involvement</u>, we strongly advocate continuation of Title X and New York State policy allowing teens to consent for their own reproductive health care without <u>parental consent</u>. The promise of confidentiality is critical to continued use of family planning services by those who need it most; teens who come from dysfunctional or abusive families, and who are alienated from other possible support systems. It is this group who convinces us most of the worth of the Title X program, and of the shallowness of the criticism against it.

Thank you for this opportunity to express our views on this subject, and to testify about our clinic services and philosophy. We urge you to reauthorize the Title X program for all it does, and all it can do in the future.

Sincerely,

James B. O'Hora

James B. O'Hora ACSW, CSW
Executive Director

THE AMERICAN FERTILITY SOCIETY

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May 4, 1989

The Honorable Edward M. Kennedy
Chairman
Committee on Labor and Human Resources
The United States Senate
Washington, DC 20510

Dear Senator Kennedy:

The American Fertility Society (AFS), an organization of 11,000 physicians and scientists specializing in reproductive medicine, is pleased to endorse S. 110, the "Family Planning Amendments of 1989", which reauthorizes Title X of the Public Health Service Act for three years. This important program provides family planning services to nearly 5 million women each year to help them avoid unintended pregnancy.

Access to and the use of effective contraception through programs such as Title X are associated with improved maternal and child health. Title X clinics also provide other beneficial health services to women such as screening for cervical cancer and sexually transmitted diseases including AIDS.

In recent years, however, funding for Title X has not kept pace with the need for services as documented in the Institute of Medicine's 1985 report Preventing Low Birthweight. In fact, funding for the program has actually declined due to an unfavorable political climate and budgetary constraints. Although funded at $142.5 million in 1985, by fiscal year 1989 Title X funding had dropped to $135.1 million. Reauthorization of the program would boost funding levels for basic family planning services to $163 million for fiscal year 1990, thus enabling health care providers to serve more women.

Our organization commends you on the contraceptive development initiative included in the bill which authorizes $10 million in additional funds for contraceptive research and development under the auspices of the National Institute of Child Health and Human Development. The need for safer and more effective methods of contraception is an important public health goal.

In conclusion, the American Fertility Society appreciates your ongoing commitment to the Title X program and pledges to work with you to gain passage of the legislation during this session of Congress.

Sincerely,

J. Benjamin Younger, MD
President

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

The American College of Obstetricians and Gynecologists (ACOG), an organization representing more than 28,000 physicians specializing in the delivery of health care to women, is pleased to comment on two important public health programs. Our membership is particularly concerned about the availability of family planning services as well as programs to assist pregnant and parenting adolescents.

TITLE X — FAMILY PLANNING

Title X of the Public Health Service Act provides voluntary family planning services for nearly 5 million women annually to help them avoid unintended pregnancy. More than 4,500 Title X clinics provide other beneficial health services, such as screening for cervical cancer and sexually transmitted diseases and basic gynecological care to low-income women, including teenagers.

The Title X program has increasingly come under attack by organizations which oppose abortion and unfortunately, Congress has failed to reauthorize it since 1985. The fact that reauthorization of this program has become so politicized is a national disgrace. Title X continues to receive funding, through the annual appropriations process. However, such a process does not allow funding to be increased even though the need has greatly expanded. As a matter of fact, under Gramm-Rudman budget cuts, funding has actually been reduced. Reauthorization of the Title X program, through S. 110, would allow higher funding levels to be established and permit programmatic changes to reflect current program needs.

Effective family planning has been positively correlated with a reduction in infant mortality and low birthweight, a leading cause of infant mortality. The relationship between low birthweight and infant mortality is well-documented. In the report Preventing Low Birthweight issued by the Institute of Medicine (IOM) in 1985, it is recommended that "family planning services should be an intergral part of overall strategies to reduce the

incidence of low birthweight infants." Family planning may reduce risk factors that lead to low birthweight such as childbearing at an early or late age (under 17 or over 34), a very short interval between pregnancies, and a large number of births.

Healthy Children: Investing in the Future, a report recently issued by the Office of Technology Assessment, also acknowledged the role of family planning in reducing the infant mortality rate and low birthweight.

Several studies indicate that there is an unmet need in this country for contraceptive services especially among teenagers and low-income women. The IOM report recommended federal subsidization of family planning services to meet this need through programs such as Title X, which is well-designed to target low-income women and teenagers, both populations at high risk for poor pregnancy outcome.

In 1984 there were over one million teenage pregnancies in the United States, resulting in a teenage pregnancy rate of 109 pregnancies per 1000 women aged 15-19. By age 20, four out of ten adolescents have had a pregnancy. Statistical studies indicate conclusively that adolescents who are sexually active are less inclined than older women to use the most effective forms of contraception. During the 1970's premarital sexual activity among young women 15 to 19 years of age increased by 52.9% percent. Today, six of every ten teenage women are sexually active by the age of 19.

The United States has the highest rate of teenage pregnancy in the developed world. For example, the rates are twice as high as those found in Great Britain, France, and Canada. Available evidence indicates that national differences in sexual activity do not adequately account for the differences in pregnancy rates. It is known that American teenagers use contraceptives less regularly and generally use less effective methods than their European counterparts. Furthermore it has been hypothesized that these differences in contraceptive behavior result from lack of access to contraceptives by American

teenagers as compared with as young people in other countries.

Some argue that access to contraceptives increases the rate of sexual activity among teenagers. This is unfounded. Female adolescents generally wait approximately 6 months to 1 year after the intiation of sexual activity to seek medical advice. Often, the first medical encounter involves a request for a pregnancy test. More than 85% of teenagers first visiting family planning clinics are already sexually active, and 50% have been so for 9 or more months. Research indicates that 50% of all teenagers do not use contraceptives during their first sexual experience. Twenty percent of first pregnancies occur during the first month after the initiation of sexual activity. Fifty percent occur during the first 6 months.

Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing, a National Academy of Sciences' report published in 1987, concluded that "the most effective intervention for reducing early unintended pregnancy in sexually active teenagers is diligent contraceptive use." The report recommends continued public support for the provision of contraceptive services to adolescents and cited Title X as one important example of such a program.

The seventh edition of ACOG's Standards for Obstetric-Gynecologic Services also states: "The sexually active adolescent female deserves special attention because of the high incidence of unintended pregnancy in this population. The gynecologist should attempt to ensure that individuals exposed to the risk of unwanted pregnancy have access to the most suitable methods of contraception." Title X clinics can play an important role in education and outreach to the teenage population for contraceptive services.

Included in the Title X reauthorization measure, S. 110, is an initiative on contraceptive research. The need for safer and more effective methods of contraception is more important than ever. ACOG urges the Committee to support this initiative. Women today

have fewer contraceptive choices in large part due to the current climate surrounding product liability. The reality has affected both the availability of contraceptives on the market as well as technological innovation in this area. Traditionally, contraceptive research and development have been carried out by the pharmaceutical industry, the federal government, and non-profit organizations. Several manufacturers are no longer carrying out such research and development due to the specter of liability suits, low return on their investments, and the long FDA approval process. These same factors also hamper small firms from carrying out innovative studies. Research in this area now falls almost exclusively to the federal government and non-profit organizations. ACOG commends the Chairman for recognizing the need for additional contraceptive research and development to assure that American women have access to the safest and most effective contraceptive methods.

TITLE XX - ADOLESCENT PREGNANCY AND CHILDBEARING

The rates of maternal mortality and morbidity are considerably higher among teenage women than for adult women. For teenagers under the age of 15, the maternal mortality rate is 60% greater than for women in their twenties. Women under the age of 18 have higher than average levels of pregnancy related complications, such as toxemia, anemia, cervical trauma, and premature delivery.

The available evidence shows that infants of teenage parents are much more likely to be of low birthweight and to die than those born to mothers over the age of 20. One of the major reasons for the high infant mortality rate among adolescent mothers is that adolescents are less likely than adult women to seek and receive adequate prenatal care during the first trimester of pregnancy. In 1986, only 53.4% of all infants born to teenage mothers received prenatal care in the first trimester. It is estimated that approximately 12.5% of adolescent mothers under age 19 receive late or no prenatal care. The best way to prevent low birthweight, infant mortality, and infant morbidity is through early and continuous prenatal care. Several studies have demonstrated that adolescents who

receive good prenatal care have pregnancy outcomes that are no different from, or better than, those of older women.

In addition to medical risks and complications, adolescent pregnancy and childbearing are also associated with a number of social and economic problems. The Center for Population Options recently reported that in 1986 the United States spent nearly $18 billion in public assistance payments to households where the mother was a teenager when her first child was born. In addition, women who have their first baby as a teenager have a decreased likelihood of completing schooling and earn less annually than women who delay childbearing. Unfortunately, repeat pregnancies are not uncommon among women who gave birth as teenagers. Adolescents who have their first baby as an unmarried teenager have a high likelihood of having a second child within two years.

In 1986, ACOG established a permanent Committee on Adolescent Health Care. This Committee is charged with developing and implementing solutions to various problems in adolescent health care including adolescent pregnancy and childbearing. In 1985, ACOG published Adolescent Perinatal Health : A Guidebook for Services. This forty-page booklet included clinical guidelines and information important to physicians who serve adolescents and emphasized the importance of a system of comprehensive services to prevent adolescent pregnancies, and bring health and others services to adolescents promptly when pregnancy occurs. Such comprehensive services, as stated in this guidebook, should focus on the "current and future well-being of the adolescent and on the prevention of additional untimely pregnancies."

ACOG supports S. 120, which would amend Title XX to establish an ongoing service program for pregnant and parenting adolescents. These services include family planning services, pregnancy testing and counseling, prenatal and postnatal care, arrangements for delivery, referral for education, employment and vocational services, and adoption counseling and

services. Also included in S. 120 is a component intended to prevent teenage pregnancy through educational services relating to sexuality and family life.

The National Academy of Sciences' report Risking the Future identified as an important policy goal the promotion of positive social, economic, health, and developmental outcomes for adolescent parents and their children. To accomplish this goal, the report recommends "continued support for the provision of appropriate health and nutrition services, including prenatal, labor, and delivery care for pregnant adolescents, the prevention of subsequent untimely and unintended births." The panel also advocates that special education programs and services for pregnant and parenting teenagers be developed and implemented to assist these young people in completing their education. Clearly, the current Title XX reauthorization measure incorporates these recommendations.

PARENTAL NOTIFICATION AND CONSENT

The issue of confidentiality has been identified by both providers and young people themselves, as a significant access barrier to health care. In fact, studies indicate that one of the major causes for delay in seeking contraception is fear of parental discovery. Fear of parental reproach is also one reason cited by adolescents for not seeking prenatal care.

Mandatory parental notification or consent also violates the confidentiality of the patient/physician relationship. The argument has been made that parents should be notified because of the health risks of prescription contraceptives. However, the health risks of pregnancy far exceed the health risks of contraception, especially among adolescents. For example, a sexually active adolescent is five times more likely to die of conditions related to pregnancy than those associated with oral contraceptives. The health care provider's primary duty is to the patient. Adolescents should not be denied care and services on the basis of mandated parental consultation. Mandated parental notification or consent may subject the patient to family friction or abusive behavior. Teenagers who do not

wish to involve their parents may not seek contraceptive services or prenatal care, thereby serving only to increase the rates of teenage pregnancy as well as infant mortality and morbidity.

Recently, ACOG, in conjunction with four other national medical organizations, issued a policy statement that, while encouraging parental involvement when possible, permit an adolescent the opportunity to be examined and counseled without the parental consent. Futhermore these principles stress that the same confidentiality be preserved between the adolescent patient and the provider as would be between the parent/adult and the provider.

ACOG thus urges the Committee to oppose any amendments that would mandate parental notification or consent for contraceptive services or participation in programs designed to assist pregnant and parenting teens.

OPTIONS COUNSELING

In recent years, there have been several attempts through legislation and regulation to prohibit counseling and referral for abortion services in programs receiving federal family planning funds. As federal funding of abortion is already prohibited by law, such attempts go beyond this restriction and are aimed at restricting the flow of information between a patient and her physician. A prohibition on the content of counseling between the patient and her physician is contrary to medical standards and severely compromises the patient's legal right to informed consent.

To eliminate any counseling or referral for abortion within the Title X and XX programs violates a basic medical principle -- the duty of the health care provider to provide all pertinent information to the patient as well as a patient's right to give informed consent. Informed consent is a legal doctrine that requires the physician to obtain consent from a patient before a medical treatment is rendered. It is a process of education and discussion

which requires active interchange between the physician and the patient. The physician must provide an explanation to the patient which should include the diagnosis, the risks and benefits, the expected outcome, and a description of any alternative courses of treatment. Throughout the discussion, the health care provider should encourage questions that facilitate full understanding by the patient of the information provided. Good health practice demands open communication between health care professionals and their patients. When health professionals are prevented from communicating honestly and adequately with those they serve, patients do not receive optimum health care. All patients have the right to decide what medical care they wish to receive. Patients can make this choice only after being fully informed by the health care provider of the risks and benefits of all available options.

The seventh edition of ACOG's Standards for Obstetric-Gynecologic Services states: "In the event of an unwanted pregnancy, the physician should counsel the patient about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offer the infant for legal adoption, or aborting the pregnancy." These standards are consistent with the current program guidelines for Title X and the reauthorization measure for Title XX. We urge the Committee to oppose any amendments which would restrict the content of counseling between a patient and her health care provider.

CONCLUSION

ACOG believes that unintended pregnancy, teenage pregnancy, and low birthweight are problems for which there are solutions. Although some of these solutions are known, public information must be combined with adequately funded service delivery programs if we are to reduce our country's high rate of teenage pregnancy and childbearing, and infant mortality. The benefits to be obtained from such efforts are real, whereas the costs to society from continued high rates of unintended pregnancy, adolescent childbearing, and low birthweight infants are enormous.

ACOG supports S. 120 and S. 110 currently before the Committee and strongly believes that such measures will have a significant impact on preventing pregnancy, reducing low birthweight, and assisting pregnant and parenting adolescents to lead more productive and satisfying lives.

the Center for Population Options

May 10, 1989

Honorable Edward Kennedy, Chairman
Senate Labor and Human Resources Committee
425 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Mr. Chairman:

The Center for Population Options (CPO) is a nonprofit educational organization dedicated to improving the quality of life for adolescents by preventing unintended teenage pregnancy and too-early childbearing. Through its domestic and international programs, CPO seeks to improve adolescent decision-making through "life planning" and other educational programs, to improve access to reproductive health care, to promote the development of school-based clinics, and to prevent the spread among adolescents of HIV and other sexually transmitted diseases.

CPO supports S.120, the Adolescent Pregnancy Prevention, Care and Research Grants Act of 1989 as a good and necessary step toward a strong federal commitment to preventing teenage pregnancy. In addition, we strongly support S.110, the reauthorization of Title X, without amendment. In this regard, we are particularly concerned that School-Based Clinics (SBCs) not be the target of restrictive amendments in Committee or on the floor.

In lieu of testimony, we would like to request that this letter be entered into the hearing record from May 9, 1989 along with the enclosed report: School Based Clinics 1988 Update. We believe that the facts on the efficacy and potential of SBCs are well represented in this report. As the Committee will see, SBCs are projects resulting from individual communities' concerns and are subject to oversight from parents and local officials. Title X represent only the tiniest fraction of support for SBCs; to date only one out of 150 SBCs nationwide receives any Title X funds. It is both unwise and unnecessary to restrict funding sources for SBCs that are not now used, and that may in the future represent a viable source of funds for pregnancy prevention efforts in these comprehensive clinics.

Thank you for your efforts on behalf of S. 110 and S. 120.

Sincerely,

Judith Senderowitz
Executive Director

enclosure

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NANP In Reproductive Health
National Association of Nurse Practitioners in Reproductive Health

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN REPRODUCTIVE HEALTH
Susan Wysocki, RNC, NP, Executive Director

As nurse practitioners providing the basic health services in family planning programs across the country, we have had the opportunity to witness, first hand, the successes of the program in promoting the health and well-being of the individuals in our communities. We have seen families remain stable and healthy and individuals who were able to pursue their goals because they were not faced with an untimely pregnancy.

We have seen the other benefits of the program as well...the woman who has had a breast or cervical cancer detected at an early stage when treatment could guarantee a full recovery...the woman who might have had a future infertility problem if the hidden infection she had was left undetected and untreated...and the mother who recently wrote "You discovered my daughter's diabetes. Thank you."

The Title X Program has not been reauthorized since 1985. Since then, the care of the family planning client has become more complex. Many patients are no longer that healthy twenty four year old that we saw when the family planning program first began. They are patients with concerns about AIDS. They are patients who frequently have infections such as chlamydia and infections caused by the human papillomavirus (venereal warts), several strains of which have been linked to cancer. From

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accounts from across the country, the family planning client has many more problems than he or she did just a few years back.

The level funding of the program, together with the rising costs of keeping the clinic doors open and the increased complexity of the patient's needs has made meeting the needs of the family planning client increasingly more difficult. As nurse practitioners, we find ourselves trying to meet the increased demands of our clients with fewer resources than we have ever had. Constant reminders of the overwhelming need to save costs leaves a cloud over our desire to provide the best care possible. For example, while we know that the incidence of chlamydia in some communities is 12% or greater, we find ourselves deliberating whether a chlamydia culture should be done based on whether the clinic can afford it. To save costs, we cannot turn away patients with these simple to detect and treat, yet serious problems. For many of our patients, family planning is their only access to health care.

The positive outcomes of the family planning program cannot be factually disputed. The evidence of the program's success comes from the nearly five million individuals in this country who continue to utilize the services and continue to be helped by the program.

Therefore, we urge the Senate Labor and Human Resources Committee to support reauthorization of the Title X program to ensure its continuation. Further, we urge the committee to maintain the integrity of the program as it has served the men and women in this country for over 18 years by opposing any restrictive amendments to the legislation.

AMERICAN JEWISH CONGRESS

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May 9, 1989

Senator Brock Adams
Senate Committee on Labor and Human Resources
430 Dirksen Senate Office Building
Washington, D.C.

Dear Senator Adams:

The American Jewish Congress is an organisaiton of American Jews founded in 1918. It has long held the conviction that the welfare of the Jewish community is inseparably linked with the health of American democracy and with the welfare of American society as a whole.

In this conviction we urge passage of S. 120 the Adolescent Pregnancy Prevention, Care and Research Act of 1989.

The problems created by teen pregnancy and child bearing both for the teen herself and for American society need no rehearsal here. Studies show that substantial numbers of teen mothers rarely complete high school, are prone to repeat pregnancies within two years and as a result are often unemployable and dependent on welfare for much of their lives. Their infants are likely to experience prematurity, low birth weight and infant mortality. If the babies survive, they often have difficulties in school and become the dropouts and unemployables of tomorrow.

S. 120 will help alleviate these problems by providing support services to pregnant teens to reduce these adverse health outcomes and to enable them to stay in school, prepare for employment and enhance their prospects for long term self-sufficiency.

As plaintiffs in a suit which challenged the Adolescent Family Life Demonstration Project, the Chastity Act, we are delighted that the new bill abandons some of the provisions contained in the prior bill that we viewed as violative of church and state separation.

We are pleased also that all grantees, although required to encourage parental and family involvement in the provision of services, may not deny such services to young people who are unable to consult their parents and that grantees must make sure that adolescents are made aware of the availability of counseling on all options regarding their pregnancy, so they can make informed decisions in this area.

The American Jewish Congress believes that this bill, by assisting teenage mothers, their families and their children, fulfills the spirit of Judaism's reverence for life and is at the same time a practical and cost effective approach to a serious national problem.

Sincerely,

Lois Waldman

Lois Waldman
Co-Director
Commission on Law
and Social Action

PREPARED STATEMENT OF ALICE C. DONAHUE, INTERNATIONAL PRESIDENT GENERAL FEDERATION OF WOMEN'S CLUBS

Mr. Chairman and members of the Senate Committee on Labor and Human Resources:

On behalf of the General Federation of Women's Clubs (GFWC), I am pleased to submit for the record this statement in support of S. 120, the Adolescent Pregnancy Prevention, Care and Research Grants Act of 1989.

For almost a century, the members of the General Federation of Women's Clubs have worked to improve the lives of people in their communities. The special needs of children have always played a prominent role in the many projects undertaken by local woman's clubs.

Today, with nearly half a million adolescents having babies each year -- young people, scarcely more than children themselves, becoming parents -- there is a tremendous need to address simultaneously the needs of these young parents and their babies. The need is equally great to teach all young people the facts about sexuality and family life and to instill in them the sense of self-respect and self-discipline that will enable them to make wise decisions.

In 1988, delegates to the GFWC International Convention adopted a resolution entitled, "Teen Pregnancy Prevention" that concluded:

> RESOLVED, That the General Federation of Women's Clubs urges its member clubs to support the establishment of coordinated programs that will:
>
> 1. Discourage teens from becoming sexually active;
> 2. Provide accessible and affordable counseling, education and health services to enable sexually active teens to prevent pregnancy;
> 3. Provide comprehensive services to teen parents, including prenatal health care to mothers, parenting education for both parents, continued educational opportunities, and affordable child care arrangements convenient to the parents' school or place of work.

In passing this resolution, our members recognized that there is a need for a continuum of coordinated educational and care services that discourage teens from becoming sexually active, that prevent pregnancy among those who are sexually active, and that minimize the potentially negative consequences of adolescent pregnancy. I am pleased to submit this statement of support today on behalf of GFWC because we believe that S. 120, the Adolescent Pregnancy Prevention, Care and Research Grants Act of 1989, will provide the structure and the monetary resources needed to create this continuum of adolescent pregnancy services. It will neither overlook the need to discourage premature sexual activity among teens, nor will it ignore the fact that, no matter how much we try to dissuade them, some teens will become sexually active and some of these will become pregnant.

Over the last several months, GFWC has been pleased to work with the National Organization on Adolescent Pregnancy and Parenting (NOAPP) and over thirty other organizations in an ad hoc coalition supporting passage of adolescent pregnancy prevention and care legislation.

I was most pleased to learn that Caroline Gaston, Principal of the New Futures School in Albuquerque, New Mexico, would be presenting testimony on behalf of NOAPP. Although I have not had the opportunity to meet Ms. Gaston, she is well known and respected by GFWC's Legislation Chairman, Mary Lee Martin of Albuquerque New Mexico. We are proud that Ms. Martin serves not only as GFWC's Legislation Chairman, but as a member of the school board for the Albuquerque Public Schools; in fact she is the immediate past Board President.

In this capacity, she has seen firsthand the positive difference the New Futures School makes in the life of young people. The school boasts a graduation rate of 73 percent, with 54 percent going on to postsecondary education. And, contrary to the misguided notion that teens become pregnant in order to receive welfare, only 16 percent of former New Futures students receive welfare benefits.

Ms. Gaston's testimony presents a thorough overview of the New Futures School program and its achievements. I will not attempt to repeat this information, but will only note that it is but one fine example of what can and must be done to deal with the challenges presented by adolescent pregnancy and parenting.

Another program of which we in the General Federation of Women's Clubs are most proud is the Mecosta-Osceola Alternative School located in a rural Michigan community. When the members of one of our clubs, GFWC-Big Rapids, learned that in their 1,100 mile rural Intermediate School District each year an average of 200 teenage girls become pregnant and 150 students drop out, they decided to take action.

Beginning in the spring of 1987, GFWC-Big Rapids members, in cooperation with other community organizations and agencies, began seeking grants from a variety of funding sources to establish an Alternative School for pregnant and parenting teens. These grant proposals resulted in an award of $8,003 from the Osceola, Michigan Department of Social Services, $10,000 from Mid-Michigan Alliance and $200 from the March of Dimes.

Other members of GFWC-Big Rapids used their professional and volunteer skills to build business and community support for the program and in September 1987 the Alternative School opened its doors. In its first year it served 28 students in 16 different class programs, working in a range of academic levels from sixth to twelfth grades.

The school strives to raise the basic skills of students who are below grade level, so as to enable them to continue their education. The Alternative School also offers an on-site day care center, which served 10 infants in the first year, so that teen mothers can focus on their studies without worrying about their children's safety. Students are also able to learn parenting skills and nutrition from the Registered Nurse who runs the day care center.

The New Futures School of Albuquerque and the Alternative School of the Mecosta-Osceola Intermediate School District in Michigan are but two examples of the positive ways communities can work to serve teen parents and their babies. We know that these programs work. We know that they are sorely needed.

We also know that if we fail to invest in such programs to help young people facing adolescent pregnancy, the future costs in economic, social and simply human terms will be much greater.

On behalf of the 400,000 members of the General Federation of Women's Clubs and the millions of American youth at risk, I thank the committee for holding today's hearing and I urge you support passage of the Adolescent Pregnancy Prevention, Care and Research Grants Act of 1989.

Thank you.

PREPARED STATEMENT OF THE ORGANIZATION FOR OBSTETRIC, GYNECOLOGIC AND NEONATAL NURSES (NAACOG)

NAACOG, a specialty nursing organization representing 22,000 professional obstetric, gynecologic, and neonatal nurses, supports Senator Kennedy's bill, S. 120, "Adolescent Pregnancy Prevention, Care and Research Grants."

Statistics on adolescent pregnancy in the United States are staggering. In 1984 alone, 1.1 million adolescents became pregnant at a total cost to society of $18 million. American teen pregnancy rates outpace rates in Britain, France, Canada, and most countries in the western world.1 The Center for Population Options estimates that all the families begun by teens in 1986 will cost the United States $5.5 billion over the next 20 years. Sadly, adolescents at greatest risk of unintended pregnancy are also those who are disadvantaged in several ways: lower socio-economic status, single parent homes, low grades, parents who are not college graduates, and no defined career plans.2 Not surprisingly, adolescent childbearing is one of the leading causes of welfare dependency in the United States.3

Obstetric, gynecologic, and neonatal (OGN) nurses play key roles all along the pregnancy continuum. As a result, we have a unique perspective on pregnant and parenting teens. OGN nurses want to and have become involved in the prevention and management of adolescent pregnancy. But, we need congressional support to implement initiatives aimed at the sexually active, pregnant, and parenting teen. We need support for the nurse in North Dakota who teaches pregnant adolescents about childbirth and nutrition so they will take better care of themselves and have a healthier delivery and baby; for the nurse practitioner in Maine treating sexually active teens; and, for the neonatal nurse in California interested in home follow up on the recently discharged at-risk infant who started life as a premature baby.

OGN nurses advocate prevention. Typically, a newly sexually active teen will not seek birth control the first year she is sexually active. Forty percent of today's fourteen year olds will become pregnant once before reaching the age of twenty, of that forty percent, fifty to seventy percent will become pregnant again within two years. Most will not complete their education. Teen mothers, scared and uneducated, need someone who will reach out to them. Community health nurses, school nurses, and nurse practitioners in clinics are in a position to identify the at-risk teen, but they must be visible and accessible to the teen who needs them. To design and staff the programs that will accomplish this these nurses need congressional and community support. Only then can we truly initiate a plan of prevention that will break the cycle begun by adolescent pregnancy.

NAACOG would like to thank Senator Kennedy, his staff, and his committee for all they are doing to address the problem of adolescent pregnancy. If, in the future, we can be of service to you in any way please do not hesitate to call us.

References

Adolescent Pregnancy Fact Sheet. 1988. The American College of Obstetricians and Gynecologists.

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PREPARED STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION

The American Psychological Association (APA), representing 90,000 psychologists nationwide, is pleased to submit testimony on the reauthorization of the Title X Family Planning Program. APA strongly supports this important, cost-effective program and commends Senator Kennedy for his leadership in introducing S. 110.

Millions of low income women cannot afford health care. Many of these women have no health insurance, but even for those with insurance, steep deductibles and copayment requirements reduce access to reproductive health services, including family planning counseling, contraception and treatment of sexually transmitted diseases. An initial visit to a physician can run as high as $60, and oral contraceptives cost as much as $14 per month.

The Title X program provides reproductive health services to millions of low-income women every year. In 1983, the last year for which data are available, family planning clinics served about 3.5 million adult women and 1.5 million adolescents younger than 19 years old. Approximately two thirds of this adolescent group were between the ages of 18 and 19.

Title X services assist recipients to reduce the chance of unintended pregnancy and the need for abortion. Additionally, they contribute to an improvement in women's health status by providing screening and assessment services which detect conditions such as anemia, hypertension, diabetes, and sexually transmitted disease, which can cause serious complications in pregnant women. Reproductive health services are an integral component of

primary health care and for many poor women, family planning clinics are their only source of health care.

Research shows that approximately half of all pregnancies each year are unintended. Sexually active adolescents, in particular, are at high risk for an unintended pregnancy. The proportion of sexually active female adolescents aged 15-19 increased from 32 percent in 1971 to 42 percent in 1982. Many of these adolescents do not use contraception at all, and of those who do, use is often sporadic. Only 48 percent of teenage women surveyed in 1982 reported using contraceptives at the time they first had intercourse. There is on average, an 11.5 month delay between initiating sexual relations and attending a family planning clinic. Often, the first visit to a clinic is prompted by suspicion of pregnancy. Research has shown that approximately 86 percent of teens who visited a family planning clinic had sexual intercourse before their first visit.

The outcome of this high level of sexual activity and low level of contraceptive use is a high rate of adolescent pregnancy—the highest among most developed countries for which data are available. Over one million teenagers become pregnant in the United State ever year. In 1981, 80 percent of pregnancies among women under 20 years old were conceived outside of marriage. Ninety percent of the pregnancies to teenagers under age 18 are unintended. Approximately half of these pregnancies are carried to term, forty percent are terminated by therapeutic abortion and ten percent end in miscarriages.

The fertility of unwed adolescent girls is an individual and social problem of considerable magnitude and consequence. Women who bear children in their teen years are at greater risk of economic and social disadvantage than women who wait till their twenties to begin childbearing. Teenage mothers, both married and unmarried, are more likely to drop out of school and, consequently, to have lower incomes. Many of these teenage mothers turn to the Aid to Families with Dependent Children (AFDC) Program to provide support for their children. In 1987, the United States spent $19.3 billion on the AFDC program, Medicaid and Food Stamps for women who started their childbearing as teenagers. For those families whose teen mothers gave birth in 1987 alone, the U.S. will spend an estimated $5.7 billion over the next 20 years.

Adolescent mothers, particularly those under age 15, are at higher risk for complications of pregnancy, maternal morbidity and mortality, and low birthweight infants. Adequate prenatal care is widely recognized as an intervention that is strongly associated with improved pregnancy outcomes. Unmarried pregnant teens, however, are less likely to receive adequate prenatal care for a variety of reasons, including lack of knowledge about its importance and lack of sufficient income.

The National Academy of Sciences, in its report titled Risking the Future, stated that the children of adolescent mothers are at greater risk for numerous health problems and are also at greater risk for social behavior problems and lower intellectual and academic achievement.

Most troubling, the report also states that the children of adolescent mothers may be more likely to become adolescent mothers themselves than are the children of women who started childbearing at later ages. Such a pattern can only perpetuate the cycle of economic and social disadvantage that so often is the consequence of adolescent childbearing.

There is general consensus that the incidence of adolescent pregnancy and childbearing needs to be reduced. There is also a need to reduce the level of unintended pregnancies among adult women. The reasons underlying the high level of unintended pregnancy in the United States are complex and solutions to address the problem must, of necessity, have several components. As the most effective means to reduce the number of unwanted and unintended pregnancies, the provision of contraceptive services must be an integral component of any solution.

Additionally, we need to expand the number of safe, effective contraceptive options available to both men and women. The Surgeon General's report on the public health effects of abortion concluded that, in addition to educating the public about methods to prevent unwanted pregnancies, we must promote a national commitment to contraceptive research for both men and women. The provision in S. 110 to provide additional funding to the National Institutes of Health for contraceptive research is a timely response to the Surgeon General's recommendation.

In sum, the provision of family planning services through the Title X program is a proven, cost-effective way to reduce unintended pregnancy. For this reason, the program should be reauthorized.

Senator ADAMS. Dr. Glasow?

Dr. GLASOW. I would like to get clarified something that I thought I heard Senator Kassebaum say. Did I understand you correctly to say that you would completely exclude any Title X funds going to school-based clinics?

Senator KASSEBAUM. I certainly would. They don't know, and I don't think anyone has intended that they would go to school-based clinics.

Dr. GLASOW. Thank you.

Senator KASSEBAUM. School-based clinics, in my mind, and nearly everybody I have talked to, really belong under the jurisdiction of the school board.

Senator ADAMS. Thank you all very much. We appreciate your testimony.

And I want to thank all of the other witnesses and those who appeared at the committee hearing this afternoon.

The committee will stand at recess subject to the call of the Chair.

[Whereupon, at 5:20 p.m., the committee was adjourned, to reconvene upon the call of the Chair.]